Georgia's FFY 2006
Comprehensive MCH Needs Assessment

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Introduction

The Family Health Branch (FHB) of the Georgia Department of Human Resources (DHR) Division of Public Health (DPH) believes that healthy, well-educated parents/caregivers and safe and economically sound communities are key to the physical, mental, spiritual, and social well-being of Georgia's children. Therefore, we are committed to empowering our families and communities through education, collaboration, and capacity building. As part of this commitment, FHB conducted a statewide assessment of needs and assets, including an investigation and analysis, or environmental scan, of some of the key factors that impact maternal, child, and adolescent health in Georgia. The assessment findings, funded through Georgia's State Systems Development Initiative (SSDI) grant, are being used to provide tools for program and organizational planning and to guide the development/implementation of the Health Resources and Services Administration's Title V Block Grant, including performance measure setting for the FHB and other statewide stakeholders.

Georgia's FFY 2006 Comprehensive MCH Needs Assessment process was implemented in five phases: 1) planning; 2) data gathering; 3) data analysis/synthesis; 4) priority setting; and 5) goal setting/work plan (Branch) development. (See Section F. Supporting Documentation – Attachment 1 for documentation of the needs assessment process. A needs assessment flow chart is provided in Attachment 2.) In Phase 1 (planning), a Project Manager and Coordinator were appointed and specific committees and teams were created to carry out the work of the needs assessment. These groups included the Needs Assessment Steering Committee, the Advisory Team, and specific work groups. In Phase 2 (data gathering), existing needs assessment materials were collected, data gaps were identified, external environmental scans were conducted, processes and instruments to collect missing data were developed and missing data was collected; and findings were organized. Needs, gaps in services, barriers to services, emerging issues, and what was working well were identified in Phase 3 (data analysis/synthesis). In Phase 4 (priority setting) core groups of both external and internal partners reviewed the conclusions of the data findings, developed specific priorities and performance measures based on data findings, and reached decisions on Georgia's response to the needs assessment, and formulated a preliminary plan within the parameters of the MCH Block Grant guidance. In the final phase (Branch work plan development), time-phased, outcome oriented action plans are being developed by the Family Health Branch sections and population teams based on assessment findings. Much of this last phase will be completed following block grant submission. Ongoing project review (on-time/on-quality, on/under budget) was conducted throughout the needs assessment process.

The groups charged with the needs assessment tasks included persons with expertise related to quantitative and qualitative measures/data bases/indicators, survey development, service and program resources, issues and policy concerns, and included persons from throughout the Division of Public Health (DPH) and the Department of Community Health (DCH), as well as external partners such as the Georgia Campaign for Adolescent Pregnancy Prevention (GCAPP),

the Georgia Chapter of the American Academy of Pediatrics, community advocates, and family members. The participants were organized into various teams, committees, and groups to carry out specific aspects of the assessment process. These included a Steering Committee, Advisory Committee, Management Team, Core Team, and several focus groups.

The Needs Assessment Steering Committee was an internal DPH group charged with the authority to make key process decisions and to allocate resources. The group also reviewed and signed off on broad level processes, products, and provided content and technical assistance where needed. Members included representatives from the Family Health Branch's (FHB) Policy, Planning, and Evaluation Section, Data Team, Maternal and Child Health Epidemiology Branch, and the Division of Public Health's Injury Prevention Program and Office of Health Information and Policy. The purpose of this team was to:

- Review the findings of the last needs assessment completed in 2000,
- Share information about key work of various entities and agencies,
- Identify top perceived needs, issues, and trends for MCH population,
- Discuss needs assessment structure and process,
- Identify key focus areas of assessment, and
- Identify additional partners and resources.

The Needs Assessment Advisory Group consisted of both internal and external partners. (See Section F: Supporting Documentation – Attachment 4 for a list of partners.) This group's key role was to identify:

- Key areas of focus,
- Additional partners, and
- Key informants.

The Advisory Group looked at the big picture of maternal and child health in the state and integrated specific information from data gathered about women, children and families in Georgia. This larger picture was used to set priorities and develop directions. The advisory group was composed of people familiar with issues facing women, children, and families of Georgia as well as those who could provide information on broader issues such as health provider concerns or family and consumer issues.

The Management Team, consisting of the Family Health Branch Director, Policy, Planning, and Evaluation Section Leader, Assessment Project Manager, and a Consultant/Writer, was formed to coordinate the needs assessment process, assign roles and responsibilities, and review and finalize work plans. Members of the Management Team also served on the Steering Committee and Advisory Group to ensure continuity. The Core Team planned specific activities; reviewed progress on a regular basis; developed corrective actions; led various working/focus groups; collaborated with relevant public health units; created a skeleton for data collection/organization; and prepared final documents. The Core Team included:

- members of the Management Team,

- FHB's Policy, Planning and Evaluations Section and Data Team staff,
- Branch programmatic planners, and
- Two interns.

Data Gathering

In order to identify the specific needs of the state MCH population, FHB used Title V indicators and measures, state determined performance measures, and other quantitative and qualitative data gathered from across the state. Collection of the quantitative data was the responsibility of the FHB's Data Team Work Group. The Data Team Work Group consisted of FHB staff and an intern that had access to information and the ability to gather data. The Work Group developed work plans; created data inventories from existing data; identified data needs and issues; collected existing data and reports; obtained missing data; collected required data elements; and organized and summarized the quantitative data. (A listing of quantitative data sources is provided in Section F: Supporting Documentation - Attachment 3. Data limitations are noted where relevant.)

A vital component of the assessment process was local perspective and input. Collection of the qualitative data was the responsibility of FHB's Policy, Planning, and Evaluation Section (PPE). Qualitative data was collected from literature review, focus groups, and key informant interviews. A total of eight focus groups were held statewide in both urban and rural locations. The groups were comprised of a cross section of MCH stakeholders, providers, and consumers including parents of children with special needs, members of the Hispanic community, parent advocates, and teens. In addition to these focus groups, key informant interviews and web-based surveys were conducted, which focused on needs, gaps, barriers, emerging issues, and what was working well in Georgia's MCH System. Examples of the key informants were CEOs and Program Directors of various external partners such as the Georgia Health Policy Center of Georgia State University, Georgia Chapter of the March of Dimes, the Enterprise Healthy Start Initiative, service providers, and policy makers.

State Priorities and Performance Measures

Qualitative data from the focus groups, interviews, and surveys along with quantitative data findings were summarized and analyzed by the Core Team. The final analysis was incorporated into a presentation made to the advisory committee during the priority setting process.

A half-day meeting was called to reconvene the Advisory Group for the purposes of presenting the findings of the needs assessment and for setting ten new state priorities. The Advisory Group developed 19 draft priorities. The draft priorities were disseminated via email to all members of the Advisory Group, Management Team, and key informants who were asked to vote for their top ten priorities. Once the voting was completed, the state priorities were finalized through discussions between the Management and Core Teams.

The FHB planners were engaged to develop new state performance and outcome measures based on the findings of the needs assessment and the state priorities. Working with the Data Team, the Branch's population teams and sections looked at specific needs and priorities related to each level of the MCH pyramid in an effort to develop performance and outcome measures that were both measurable and meaningful to the work of the Branch. Certain aspects against which these measures were developed included the changing roles of the health departments, changing population demographics, the changes taking place in Georgia's political environment, impact of Medicaid managed care, changes in Medicaid eligibility, and emerging issues such as reduced access to care and the rising teen birth rates in the Hispanic population.

Development of activities that will contribute to positive impacts on the state performance and outcome measures will take place over the next fiscal year. These activities will be reported on in Georgia's FY 2007 Title V Block Grant application.

Needs Assessment Strengths and Weaknesses

The collaborative efforts of the Advisory Group were outstanding and resulted in several separate collaborative relationships developing outside of the needs assessment. Some difficulties arose around the scheduling aspects of the key informant interviews and focus groups, as many of the key informants had their own programs to manage and transportation and childcare for consumers were often a problem. In addition, though there were several committees and work teams involved in the needs assessment process, no single individual's time was devoted solely to the management of the project. The existence of an assessment team comprised of assessors, schedulers, analysts, and a possible consultant would have streamlined the work. In the future, the FHB may enter into an agreement with a contractor to schedule, perform, and summarize all interviews and focus groups as well as summarize and analyze all data findings.

B. Five Year Needs Assessment

Georgia's Federal Fiscal Year (FFY) 2006 Maternal and Child Health (MCH) Title V Block Grant application marks the beginning of a new five-year planning and implementation cycle. Beginning with FFY 99, when the Health Resources and Services Administration (HRSA) restructured the MCH Block Grant to include a comprehensive needs assessment and service delivery based on population groups and pyramid levels, efforts in Georgia have reflected this approach. Moving forward, our FFY 2006 MCH needs assessment, priority setting, and identification of state designated performance and outcome measures, as well as the annual plan, build upon the work of past years while reflecting new directions, emerging trends and responses to the current environment.

The major elements of Georgia's FFY 2006 needs assessment include the in-depth state profile below, which incorporates an environmental scan, a comprehensive data profile of maternal and child health in the state, and input gathered from stakeholders, partners and consumers.

Overview of the State

Over the past five years, the continuing evolution of trends already underway, as well as marked changes which followed the economic downturn resulting from the collapse of the technology bubble further exacerbated by the post 9/11 reaction, have combined to recast the future with new challenges and opportunities. Underlying dynamics, including changing demographics, health behaviors, economic shifts, and restructuring of the health care delivery system, have continued to affect the overall environment in Georgia. Some of these trends, such as substantial population growth, the influx of non-English speaking immigrants, and poor nutrition and lack of physical activity, have now reached a critical mass with significant impact on the MCH system. The MCH system has been furthered impacted by more immediate shifts in the economy and in policy directions. As a result of the economic downturn, government revenues have dropped. At the same time, increased demands are being placed on the safety net while health care costs are rising sharply. This has created an overriding dilemma of dealing with increased needs with reduced resources. Early evidence exists that Georgia may be emerging from this vicious cycle; however, we anticipate lasting impacts over the next five years.

State Profile: Georgia is the largest state east of the Mississippi River with the country's ninth largest population, moving from eleventh to ninth over the past ten years. The state's growth over the last decade comes from a combination of natural increase (i.e., births versus deaths) and domestic and international migration. In 2004, the U.S. Census Bureau estimated that Georgia's population was 8,829,383, an increase of 152,923 since 2003. The size of the population increase, approximately 150,000 persons each year, has slowed somewhat over the past decade. The percent increase has decreased to 1.8% from the higher percentages of around 2.5% in earlier years. Georgia remains the fifth fastest growing state nationally, both numerically and percentage-wise. Along with Florida, Texas, and Virginia, Georgia had at least ten counties among the fastest growing counties in the U.S. between 2003 and 2004. A major component of this growth has been the state-to-state migration flow from Florida to Georgia, 157,000 persons

between 1995 and 2000, the sixth largest interstate population shift. By 2010, the state's population is projected to grow to 9.6 million persons.

Embedded in the population growth is a fundamental shift in Georgia's population that goes beyond an increase in numbers. Since the 1990 Census, Georgia has moved from a largely rural state with urban clusters to an urban state with rural areas. This change, for the most part, has not been well recognized and further, has not been acknowledged in many planning efforts. Traditionally, Georgia was described in terms of "two Georgias" – economically strong urban and less economically advantaged rural. What has now emerged is as many as six distinct groups among Georgia's 159 counties:

1. ***Well-established metropolitan statistical areas*** (MSA) – the eight core counties in the seven previously designated MSAs;
2. ***New metropolitan statistical areas*** – the seven core counties in the newly designated MSAs, which were based on data from the 2000 Census. Seven of the 49 new MSAs in the U.S. are located in Georgia;
3. ***Suburban*** – 53 counties that are part of the 14 designated MSAs in Georgia;
4. ***Micropolitan statistical areas*** – 27 rural counties that have small core urban areas which serve as a stimulus for supporting the local economy;
5. ***Traditional rural*** – 36 counties, some of which are showing significant growth that may move them into micropolitan or even suburban status over the next ten years, and others that are clearly areas of the state where growth has been stagnant; and
6. ***Declining rural*** - 28 counties, almost all in south Georgia, where population declines have been experienced since the 2000 Census, with declines projected through 2010.

Well-established metropolitan statistical areas: Until the recent designation of seven new Georgia MSAs in 2004, there were seven MSAs in the state: Atlanta (Fulton/DeKalb Counties), Columbus (Muscogee County), Albany (Dougherty County), Athens (Clarke County), Savannah (Chatham), Macon (Bibb County), and Augusta (Richmond County). Except for Athens, the home of the University of Georgia, these MSAs were all concentrated around the state's older, well-established cities. These core areas have been marked by well-developed infrastructures with upper and middle class areas as well as impoverished communities. While Atlanta and, to a lesser extent, Athens have continued to grow, the remaining MSAs have evidenced population and economic declines as their central cores deteriorate, while surrounding suburban areas expand.

New metropolitan statistical areas: Based on the 2000 Census, seven new MSAs, in what were previously classified as rural areas, have been designated. These MSAs are: Brunswick (Glynn County), Hinesville/Fort Stewart (Liberty County), and Valdosta (Lowndes County) in the southern part of the state; Warner-Robbins (Houston County) in central Georgia; and Dalton (Whitfield County), Gainesville (Hall County), and Rome (Floyd County) in northern Georgia. With these designations, there is a contiguous urban area stretching from Chattanooga, Tennessee through Atlanta into east-central Alabama and another contiguous urban area, with the exception of two counties, reaching from Augusta along the Savannah River down through

Savannah and along the coast to Jacksonville, Florida. These new MSAs are marked by their location along the interstate highway system, which was built in the 1970s.

***Suburban*:** The number of suburban counties nearly doubled from 27 to 53 in the decade between the 1990 Census and 2000 Census. Eight of these suburban counties were added as a result of the expansion of the Atlanta MSA, eight were included as expansions of the other previously designated MSAs, and the other 37 counties are part of the newly designated MSAs described above. All 53 of these counties were classified as rural until their recent redesignation.

The largest growth, both geographically and population-wise, occurred in the suburban areas surrounding Atlanta. Eight new counties were added. Only one, Dawson County, was north of the city. The remaining seven counties were all to the south and west. The designated Atlanta MSA extends into Alabama. Its size now exceeds that of the state of Massachusetts, the ninth smallest state in the U.S. and the combined income of the area's population is larger than 35 of the 50 states. The greater Atlanta metro area includes more counties and is only separated by one county from the greater Chattanooga, Tennessee and Greenville, South Carolina areas and by two counties from the Birmingham, Alabama area. Metro Atlanta now covers 14.5% of the state, up from 10.5% a decade earlier. This sprawl has resulted in a footprint that makes Atlanta the sixth largest MSA in the country. The MSA now ranks among the nation's largest ten metro areas in both population and area.

Metro Atlanta's development has led to a pattern of low residential density, separation of residential from commercial and job centers, and limited accessibility to services and commercial/business areas. Other effects include increased air pollution and more fatal accidents and more driving. In a recent study examining different aspects of development in 83 metropolitan areas, Atlanta ranked 4th as the most sprawling area in the country.

Of the metro areas with more than 2,000,000 residents, only Riverside/San Bernardino, California and Phoenix/Mesa, Arizona grew faster than Atlanta between 2003 and 2004. Only four other metropolitan areas are getting more people per year than Atlanta: Chicago, Los Angeles, New York and Riverside/San Bernardino. While Atlanta's growth continues, it is not at the record rates seen during the 1980s and 1990s when increases averaged 66,000 a year in the 1980s and 87,200 residents in the 1990s in the core ten-county Atlanta metro area. In 2004, this core area had an increase of 46,800 residents. Since 2000, the percent change was greatest in Forsyth, Henry, Newton, Paulding, and Cherokee counties where the five-year change was 34.0%, 33.6%, 31.5%, 29.7%, and 23.1% respectively. Population-wise, Fulton County remains the largest county in the area with 852,500 residents. DeKalb County is the second largest with 695,100 and Gwinnett is third largest with 670,800 people; however, Gwinnett, which has gained the most new residents in the last year (almost 27,000 persons), may soon move into second place. Growth in the urban core of Fulton and DeKalb counties has remained flat or decreased slightly.

Looking at this growth compared to the U.S. as a whole, in 2004 for the first time in at last four years, no metro Atlanta county ranked among the ten fastest growing counties in the U.S. However, Newton (13th), Henry (15th), Forsyth (16th), and Paulding (20th) are ranked in the top

20 fastest growing counties. Over a five-year period, Forsyth County had a 34.0% growth ranking it 6th nationally, Henry had growth of 33.6% (7th), Newton increased by 31.5% (9th), and Paulding ranked 11th nationally with 29.7% growth. The impact on services in these fast growing counties is significant. For example, in Newton County, one out of every three residents was a newcomer in the past five years and all of them require services.

The city of Douglasville in Douglas County is the fastest growing city in the state and the 11th fastest growing city in the U.S. In a one-year period between July 2002 and July 2003, Douglasville added almost 3,600 residents. Three other cities in Georgia were also in the top 25 fastest growing cities in the nation: Canton and Woodstock, both in Cherokee County, were the 12th and 25th fastest growing cities, while McDonough in Henry County was the 21st fastest growing city. Growth in these areas is being driven by housing prices that are below the metro regional average of $175,700. These areas also offer a relatively close commute into Atlanta or the rapidly growing business centers in the closer suburbs of Cobb, Fulton and Gwinnett Counties. For example, in Douglasville, 60% of the working population leaves the city every day heading east to their workplaces. At the same time, beginning in 2000, the city of Atlanta reversed a 30-year downward trend of population decline, gaining 5,400 newcomers in the most recent year.

While the growth cited above is remarkable, these areas are finding themselves having to deal with emerging issues that had in the past been associated with traditional urban areas. Social problems such as juvenile crime and child and domestic abuse are increasing along with the need for basic infrastructure such as education, health and child care services. For example, in Henry County child welfare caseloads have risen 20% and requests for in-home services for the elderly increased by nearly 40%. Henry also leads the metro area in the growth of its school system, with an increase of 8.6% in one year resulting in the need for substantial new school construction. More than one in eight Henry County residents receives Medicaid. At the same time, many of these suburban counties are not big enough to receive federal Community Development Block Grant funds, as the threshold for receipt of these funds is a population of 200,000. These rapidly growing suburban counties may quickly find themselves emulating the experience of Cobb and Gwinnett Counties, which saw similar growth in the 1980s and 1990s, by forming collaborative health and social service networks.

Micropolitan statistical areas*:* Of the 565 micropolitan areas newly created by the U.S. Office of Management and Budget in 2003, 19 are in Georgia. These once rural areas, with populations between 10,000 and 50,000, fall within the influence of bordering MSA suburban counties.

Traditional rural: The population in many of the 36 traditional rural areas grew only as a result of an increase in births to impoverished single mothers, not because of in-migration.

Declining rural: The early years of the twenty-first century have been marked by a population decline in these 28 counties, which is projected to continue for the remainder of the decade. These counties, nearly all in rural south Georgia, have lost population as a result of the lack of a diversified economy, trouble in agriculture and timber, and the inability of the small scale economies in these counties to withstand the overall downturn in the state and national economy.

As employers exited, so did people. With an already small population, these counties face major problems providing fundamental public services.

While population is a significant consideration in service and delivery planning, the political framework is also an important factor. With 159 counties, Georgia has the second highest number of any state. Only four of these counties have populations in excess of 500,000 (Fulton, Cobb, DeKalb and Gwinnett) with another 18 having populations of over 100,000. The remaining 137 counties have fewer than 100,000 population with 86 of them having populations of less than 25,000. Counties are challenged to support local services, such as health, education and social services, with these small tax bases.

Population Characteristics: While population growth portrays one aspect of the recent trends in Georgia, underlying shifts in the composition and characteristics of the state's population illustrate further changes. The charts that follow highlight these changes.

Population, Georgia Compared to US (2000 Census)

Characteristic	Georgia	US
Persons under 5 years old	7.3%	6.8%
Georgia persons under 18 years old	26.5%	25.7%
White persons	65.1%	75.1%
Black persons	28.7%	12.3%
Asian	2.1%	3.6%
Other race	4.2%	8.9%
Hispanic/Latino origin	5.3%	12.5%
Foreign born persons	7.1%	11.1%
Language other than English	9.9%	17.9%
High school graduation	78.6%	80.4%
Bachelor's degree or higher	24.3%	24.4%

Source: U.S. 2000 Census Bureau

Changes in Georgia's Population

Population Characteristics	1990 Census		2000 Census	
	Number	Percent	Number	Percent
AGE				
• Under 5 years	495,000	7.6%	595,000	7.3%
• 5-9	487,000	7.5%	616,000	7.5%
• 10-14	467,000	7.2%	608,000	7.4%
• 15-19	497,000	7.7%	596,000	7.3%
• 20-24	523,000	8.1%	592,000	7.2%
• 25-44	2,191,000	33.8%	2,653,000	32.4%
• 45 and over	1,822,000	28.1%	2,548,000	30.9%
RACE/ETHNICITY				
• White	4,600,000	71.0%	5,327,000	65.1%
• Black/African American	1,747,000	27.0%	2,349,000	28.7%
• Asian	76,000	1.2%	173,000	2.1%
• American Indian/Alaska Native	13,000	0.2%	22,000	0.3%
• Some other race	42,000	0.6%	200,000	2.5%
• Two or more races			114,000	1.4%
• Hispanic/Latino	109,000	1.7%	435,000	5.3%
NATIVITY/PLACE OF BIRTH				
• Born in U.S.	6,305,000	97.3%	7,520,000	91.9%
• Born in Georgia	4,180,000	64.5%	4,736,000	57.8%
• Born in different state	2,123,000	32.8%	2,784,000	34.0%
• Born outside U.S.	173,000	2.7%	577,000	7.1%
• Foreign born, entered U.S. in last 10 years	90,000	1.4%	345,000	4.2%
REGION OF BIRTH OF FOREIGN BORN				
• Europe			74,000	12.9%
• Asia			146,000	25.2%
• Africa			40,000	7.0%
• Oceana			2,000	0.4%
• Latin America			300,000	52.0%
• North America			14,000	2.5%
LANGUAGE SPOKEN AT HOME				
• English only	5,700,000	95.3%	6,843,000	90.1%
• Language other than English	284,000	4.7%	751,000	9.9%

Population Characteristics	1990 Census		2000 Census	
	Number	Percent	Number	Percent
HOUSEHOLD TYPE				
• Family households with own children under 18	633,000	26.8%	1,051,000	35.0%
• Married couple family with own children under 18	189,000	8.0%	733,000	24.4%
• Female household, no husband present, with own children under 18	33,000	1.4%	258,000	8.6%
• Male household, no wife present, with own children under 18			61,000	2.0%
• Households with individuals under 18			1,174,000	39.1%
• Grandparent responsible for grandchildren in households with grandparent living in household			92,000	4.7%
EDUCATIONAL ATTAINMENT				
• Less than 9th grade	484,000	12.0%	393,000	7.6%
• 9th to 12 grade, no diploma	686,000	17.0%	718,000	13.8%
• High school graduate	1,193,000	29.7%	1,486,000	28.8%
• Some college/associate degree	884,000	22.0%	1,329,000	25.6%
• Bachelor's degree	520,000	12.9%	830,000	16.0%
• Graduate or professional degree	257,000	6.4%	430,000	8.3%
Percent high school graduate or higher		70.0%		78.6%
Percent Bachelor's degree or higher		19.3%		24.3%
DISABILITY STATUS				
• Age 5 to 20 with disability			158,000	8.2%

Source: U.S. Census Bureau

Race/Ethnicity: Data from the 2000 Census, the latest available data, highlights the exceptional growth and increasing diversity of Georgia. With a population growth double the national average (13.2%), lagging only behind California, Texas, and Florida in terms of population increase, Georgia ranks as the ninth most populous state in the U.S. and the fastest growing state east of the Rockies. This growth is driven by natural increase (i.e., births versus deaths), domestic migration and international migration. About one in four of the state's current

residents did not live here ten years ago. Georgia is now the thirteenth top destination for international immigrants and second for domestic migrants. Much of this escalation is concentrated in the 28-county Atlanta Metropolitan Statistical Area (MSA), which drew two-thirds of the overall state increase over the past ten years. Metro Atlanta ranked fifteenth in the U.S. in net international migration in the decade between 1990 and 2000. As part of this trend, the African born Black population in metro Atlanta increased 285% during this time period.

An increasing stream of Blacks have been moving to the South. Georgia is the most popular choice for Blacks moving from other states. It ranks 3rd nationally, behind New York and Texas, in the number of Blacks and 5th in the percentage of Blacks in the overall population of the state, behind the District of Columbia, Mississippi, Louisiana and South Carolina. Blacks account for 19.2% of the disposable income in Georgia. Atlanta experienced an 84% growth in middle- and upper-income Blacks between 1990 and 2000, leading the nation. The Atlanta MSA now has the nation's highest percentage of Black middle-income households (38%), with more than half of the households earning at least $35,000.

With the influx of Black professionals into the metro Atlanta area, the income gap with Whites narrowed during the 1990s. Most of the income gains occurred in the suburbs, with higher income Blacks moving into what have been traditionally largely White communities, creating a ring of Black affluence around the core of Atlanta. However, the median income of Blacks is still only about three-quarters of the White household median of $59,185 in 2000. Yet, the median income of Black households rose 25.6% while that of White households rose only 14.2% during the 1990s. In Fayette County, which had the second fastest growing Black population in the U.S. in the 1990s, the Black median income is higher than the White income.

The income trend for Blacks in the metro Atlanta has been consistently up; however, pockets of poverty remain in the region. The 2000 Census indicates that Atlanta has experienced the greatest growth nationally (84%) in middle and upper income Black households (229,000), ranking first in the U.S. In the ring of counties circling Atlanta – Barrow, Cherokee, Coweta, Henry and Paulding – Black median household incomes increased two to three times more than that of Whites. For example, in Forsyth County, where the number of Blacks in 1990 was not great enough to be included in the 2000 Census Income Survey, the Black median income of $41,989 eclipses the metro Atlanta median for Black families of $39,073. In the suburban counties outside the perimeter, a contiguous ring of census tracts is emerging where the Black median income is between $65,000 and $200,000. In the core five counties of the metro area, the percentage of Blacks has risen from 13% to 15% in Gwinnett County and two counties, DeKalb and now Clayton, have a majority Black population. In fact, Clayton now has the highest percentage of Black residents in the metro area, 59%; the percentage of White Clayton residents fell from 35% to 26% over a three-year period starting in 2000. This may be driven by the county's low taxes and abundance of less expensive housing.

Reflecting national trends, the number of Asians and Hispanics in Georgia have shown dramatic increases, which are projected to continue. Prior to the 1990's, almost all of the foreign born people living in Georgia were either migrant agricultural workers or a small nucleus of Southeast Asians and Mexicans in the core Atlanta area. With the booming economy in the early 1990s,

these already settled residents, mostly men, formed the foundation for supportive communities that brought relatives, friends and neighbors to the state. Latinos, primarily Mexicans, are the most rapidly growing minority group and now reside throughout Georgia. In 2000, this group represented 45% of all foreign-born Georgia residents. Asians have a long immigration history which until recently consisted of small numbers of Koreans and Chinese settling in the metro Atlanta area. Over the past 15 years, the number of Asians has increased along with significant diversification. Large numbers have arrived from Southeast Asia – Vietnam, Philippines, Laos, Thailand, Cambodia – and from the Indian subcontinent – India, Pakistan – and have settled in the state's metro areas. Asians comprised 25% of foreign-born Georgians in 2000. Indians now constitute the largest Asian population group in the state with a 271% increase during the 1990s, ranking 7th in numeric growth of the population and 4th in terms of percent increase. Driven by upheavals in their countries of origin, recent waves of eastern Europeans and Africans have also migrated to Georgia. Immigrants have arrived from the former Soviet republics and Soviet block nations, including war-ravaged former Yugoslavia. Similarly, Africans displaced by famine and war have arrived as refugees from Ethiopia, Somalia, Eritea, and Africans from other nations have arrived seeking economic opportunities. While Arabs have a long history of immigration to the U.S., their experience settling in Georgia is relatively new. This new group of immigrants consists of both Muslims from Africa and the Middle East.

The number of undocumented immigrants in Georgia is estimated by the Immigration and Naturalization Service to have increased six-fold since 1996, with an estimated 228,000 undocumented immigrants in 2000. Georgia and nine other states together contain an estimated 78% of the undocumented residents in the U.S. The magnitude of the state's increase far exceeds that seen in other states experiencing these changes, such as North Carolina and Arizona. Their arrival, mostly Mexican nationals, has been driven by job opportunities in major industries around the state such as the textile and poultry plants in north Georgia, service industries in metro Atlanta, and agricultural operations in south Georgia.

Current immigrant settlement patterns in metro Atlanta differ significantly from the traditional inner city pattern. Between 1995 and 2000, of the almost 163,000 immigrants moving into the metro region, only 10% moved into the city itself. This may be different from other parts of the country as the city of Atlanta's size is relatively small in relation to the rest of the region. Also, in the metro area, job opportunities tend to be outside the city limits. The settlement pattern further reflects the traditional tendency of concentrations of individuals from the same country of origin, or even regions within a country. The more concentrated these immigrant clusters are, the lower the median income of the group in that cluster tends to be. As income increases and language skills improve, these immigrants are able to move out of what were initially "comfort zones."

In the 2000 Census, Georgia ranked 23rd nationally in its Hispanic/Latino population, with the growth being the fourth fastest in the nation. The state's Hispanic population increased three-fold and in 2000 constituted 5.3 % of the state population. It increased to 6.3% in 2003. Three counties – Whitfield and Hall in the north and Echols on the Florida border – now have populations with over one in five Hispanic residents. With 22% of its residents being Hispanic, Whitfield County leads the state. The growth, however, may have been most spectacular in

Gwinnett County, which experienced a 657% increase in its Hispanic population, growing from 9,000 to 64,137 persons, almost edging out DeKalb County as the largest Hispanic population in the state.

Since the 2000 Census, this growth has been even more dramatic. Georgia's Hispanic population grew faster than any other state between 2000 and 2002 with a growth of 17%, bringing the total number of Hispanics to 516,500. About 6% of all Georgians and 7.5% of those in the metro Atlanta area are Hispanic. Metro Atlanta, during this same time period, experienced the most rapid growth rate among the nation's 20 most populous metro areas. While the population in the region increased overall by 9%, the increase in the Hispanic population was 30% and the increase in the Asian population was 23% as compared to an 11% in the Black population and 7% in the White population. Gwinnett County, in the core metro area, has the highest concentration of Hispanics in the metro area, 13%. Dawson County, on the fringe of the metro area, exhibited the most dramatic increase, a growth of 59%, bringing the total Hispanic population in the county to 2%.

In Georgia, Latino men still far outnumbered women in 2000, as seen in metro Atlanta where there were 169 Latino men for every 100 women. This contrasts with the national average of 107 men for every 100 women. This nucleus of men has provided the foundation for family formation, as family members and others have moved to Georgia. The state ranks 4th in the country for the largest Hispanic family size, 4.14 people (state average family size is 3.25). This may be a factor of the recent arrival of Georgia's Hispanic population as the family size tends to decrease in second and third generations.

A recent study found that immigrant mothers now account for almost one-fifth of the state's births. Georgia has experienced one of the largest increases in immigrants in the country. In 1970, about 1% of all births in the state were to immigrant mothers. By 2002, births to immigrant mothers had increased to 19% of all Georgia births.

The Hispanic population in Fulton County under the age of four has grown by 42% between 2000 and 2002 and now constitutes just over 10% of all children in the county. Similar growth has been seen in Coweta, Gwinnett, Cobb, Rockdale, Forsyth and Bartow counties in metro Atlanta. In Gwinnett, almost 20% of all children age four and under are Hispanic. Coweta's population of Hispanic infants and toddlers grew by 45.2%, the largest jump in metro Atlanta. Overall, the number of Hispanic children age four and younger grew by 36.5% in Atlanta's 28 county metro area, an increase of 10,774 children in just two years, exceeding the overall Hispanic growth rate in the area, which was 22.8%. Many of these young children are being born in Atlanta area hospitals, not immigrating from their native countries.

This growth impacts government and health services. At Gwinnett Medical Center Women's Pavilion, 24% of the birthing mothers admitted in 2003 were Hispanic compared to 17% in 2000. At Northside Hospital Cherokee, 32% of all babies born in 2003 were Hispanic compared to 23% in 2000. Likewise, 14% of babies delivered at WellStar Cobb Hospital in 2003 were Hispanic compared to 6% in 2000. In Atlanta, at Grady Memorial Hospital, the largest public hospital in the state, 42% of the babies born in 2003 were Hispanic compared to 30% in 2000,

and at Atlanta Medical Center, 37% were Hispanic in 2003 compared to 12% three years earlier. Centro International de Maternidad, a private OB/GYN clinic group serving uninsured immigrant women who are not covered by regular Medicaid, founded in 2002, has grown from one to four clinic sites. The Clinica de la Mama in Norcross (Gwinnett County) provided care for 2,200 pregnant women in 2004, almost three and a half times as many as the 600 women served in 1998 when the clinic opened. Clinica de la Mama is part of a growing metro Atlanta network of seven prenatal clinics for Spanish-speaking women. The network will open another clinic in Gwinnett County (Lawrenceville) later this year.

The growth in the state's Hispanic families is also evidenced by the growth in the number of Hispanic students in the public schools, rising by almost 90% in the state. Two of Georgia's counties, Gwinnett (863%) and Hall (676%), ranked first and second nationally as the counties with the highest population growth of school age Hispanics from 1990 to 2003, and Cobb (496%) and Clayton (461%) rank fifth and seventh respectively. One example of the impact this growth has had on Georgia's schools is seen in the Fulton County School System, which hired interpreters 500 times in 2004 to assist with events such as parent teacher conferences, compared to only 36 times four years earlier.

While the numbers are not as dramatic as with the Hispanic population, the Asian population has grown almost 200% and totaled 173,170 in the 2000 Census. This rate of growth ranked Georgia, only behind Nevada, with the 2nd highest Asian growth rate and 19th overall in the percent of its Asian population. The 2000 Census revealed that unlike the pattern in the rest of the country, where Chinese are the largest Asian group, in Georgia, the Indian community is largest. About 46,000 Indians live in the state compared to about 29,000 Vietnamese, 28,700 Koreans, and 27,500 Chinese. The Indian community grew 231% during the last decade. Approximately 73% live in the core five county Atlanta area. The pattern is similar with Vietnamese, Koreans and Chinese – about 75% live in the same five counties. Between 2000 and 2003, the Asian population has continued to grow at a rapid pace, growing from 2% of the overall state population in 2000 to 2.4 % in 2003. In metro Atlanta during the same time period, in Cobb County the Asian population has grown by 20% while Gwinnett, the county with the largest Asian population, has grown by 26%.

Age: Georgia's population continues to grow younger compared to the U.S. as a whole, ranking 6th in terms of the lowest median age. In 1990, Georgia was not even the youngest state in the south; by 2000 the only states in the country with a younger population were all in the west. This trend represents a combination of a baby boom and huge numbers of young professionals from other parts of the country and working age immigrants moving to Georgia. The state ranks 4th nationally in the percent of its population who are of working age. In the 13 core metro counties in Atlanta, 11 had a median age below the nation's and eight, including the four largest metro countries, had a median age below the state's median. The youngest Atlanta metro county, Clayton, had a median age of 30.2 years.

A total of 1,026,000 families with children age 17 or younger lived in Georgia in 2000. Sixty-six percent of all married families have children this age, ranking Georgia seventh nationally. Georgia was one of five states with more than a 25% increase in the number of children between

1990 and 2000, trailing Nevada, Arizona, Colorado, and Florida. Georgia was one of six states (Arizona, Nevada, Florida, North Carolina, Colorado and Georgia) in the nation that experienced an increase in its elementary school-age population between 2003 and 2004. Families with children are filling the outer counties surrounding Atlanta, putting a strain on services. The largest increases in the number of families with children since 1990 occurred in Forsyth, Henry, and Paulding Counties where the number of families have more than doubled.

Children with Special Health Care Needs (CSHCN)*:* A national study conducted by the Data Research Center for Child and Adolescent Health provides characteristics of Georgia's child population with special health care needs. Based on this study, 12.7% of children and youth, ages 0 to 17 years old, in Georgia have special health care needs. This is comparable to the national rate of 12.8%. The percentage of households with children who have CSHCN is 18.9%. Looking at these children by age reveals that 8% of CSHCN are 0 to 5 years old, 15.1% are 6 to 11 years old, and 14.8% are 12 to 17 years old. The prevalence of males (14.9%) is significantly greater than females (10.4%). Examining CSHNC by race/ethnicity indicates that the highest percentage (14.6%) is among Whites while the lowest percentage (5.2%) is among Hispanics, with 11.6% of Black children having a special health care need(s). The greatest percentage of CSHCN is found in families whose income is between 100 and 199% of federal income poverty level (14.8%).

Of the CSHCN, 23.7% had health conditions that greatly affected their daily activities and 15.9% of them missed 11 or more days of school due to illness. Only 3.3% of CSHCN were currently uninsured; however, 37% indicate that their insurance coverage is not adequate. Just over 13% of these children did not have a personal medical home and 23% of the families whose children needed specialty care indicated problems getting a referral. As a result of their child's health needs, 21.9% of families experienced financial problems and 37.2% indicated family members had to cut back or stopped working due to the child's health needs.

Family Household Types: Between 1990 and 2000, the number of married couple households with children dropped 2.4% in Georgia to 24.37% of all households. During the same time period, the number of female headed households with children increased by 0.6% to 8.6% of all households and percent of male headed households with children increased by the same amount to 2%.

All parents are in the labor force in 60% of the households with children under the age six and 70 percent of the households with children between six and 17 years of age. The number of children living in a two-parent household where only the mother works increased by 110 % from 1990 to 2000 compared to the national shift of 102%. In metro Atlanta counties, some striking increases have occurred with the percent increasing by 393% in Paulding County, 391% in Gwinnett, 330% in Cherokee, 296% in Henry, and 246% in Cobb.

Georgia ranks 21st in terms of grandparents as primary caregivers. In 2000, 193,825 grandparents lived with their grandchildren and of those, 47.6% or 92,261 grandparents are primary caregivers in households without the parents of their grandchildren. One out of every 13 Georgia children is living with a grandparent, with the figure higher among Black children, just

under one out of every eight. Nearly 6.5% of children in metro Atlanta lived with grandparents in 2000, a slight increase from 1990. In suburban Spaulding County 11.6% lived in a "grandparent with child" home and in DeKalb, the second highest percentage in metro Atlanta, 9.2%, lived in such a household. A Census Bureau study revealed that in one-third of such homes, the biologic parent is gone, dead, or jailed. Substance abuse is found in 70% of parents of the children who are being raised by a grandparent. The role of grandparents or other extended family members becomes particularly important in providing parenting support to the state's young unwed mothers. The percent of births to unmarried females has increased from 37% of all births in 1999 to 38% in 2003.

Metro Atlanta has experienced a phenomenal increase among singles who may eventually be forming families. Atlanta attracted more singles between ages 25 and 39 (31,900) than all metro areas except San Francisco and Los Angeles between 1995 and 2000. This has affected Georgia's median age, 33.4 years, the youngest of any state east of the Mississippi.

Educational Attainment: In 2003, 1,807,000 Georgians age three to 18 were enrolled in school. Of these youth, 298,000 were enrolled in nursery, pre-kindergarten or kindergarten; 1,020,000 were enrolled in elementary grades 1-8 and 488,000 were enrolled in high school grades 9 –12.

Overall, Georgia ranks 14th nationally in the percent of its population 25 and over without a high school diploma, 1.1 million persons. Roughly 35% of its adolescents enter the adult workforce without a high school diploma. Only 64.2% of Georgia high school freshmen earn their diploma in four years, just slightly more than Louisiana, which has the worst performance in the country. SAT scores in Georgia continue to lag with the state ranking 49th in average SAT scores in 2004. Conversely, the percent of the state's population with a college degree or advanced degree is similar to the national average. The city of Atlanta ranks 4th with the most post graduate degree holders in 2002 behind Washington, DC, Seattle and San Francisco. Cobb County is the most educated county with 14.5% of its residents holding an advanced degree, ranking 39th nationally of all counties; Fulton ranks 45th, DeKalb 60th, and Gwinnett 156th out of the 238 most highly educated counties in the U.S.

Income: According to the 2000 Census, the median income of Georgia's residents continued to improve, rising from 42nd in U.S. rank in 1960, at the birth of the "New South," to 22nd in 2000. In 2003, the state's three-year average median income rose to $43,535, putting Georgia at the same level as the U.S. median income and improving its rank to 19th in the U.S. The state's growth in wealth is closely tied to the types of jobs available, particularly in metro Atlanta. Sixty to seventy percent of the 100,000 jobs added between 1990 and 2000 were created in the Atlanta MSA. However, with the economic downturn beginning in 2000, a decline began which erased income gains achieved in metro Atlanta, the economic engine of the state.

During the 1990s, the metro Atlanta region's income surged 13%. But, between 2000 and 2003, its median income slid 10%, almost wiping out the gains of the previous decade. Median income rose between 1990 and 2000 from $50,800 to $57,300; however, the median income fell back to $51,654 in 2003. The increase during the 1990s was most dramatic in Fulton County, rising 22% but the decline in this county was also the largest of the five core county area, falling 15%.

While the median income of Whites, Blacks and Asians rose between 1990 and 2000 in the larger ten county metro Atlanta area, the median income of the Hispanic population, which grew so rapidly, fell by $4,000 to $13,900. As this occurred, there was a five-fold increase in the poverty rate among Hispanics.

In 2003, 28.3% of the households in Georgia had annual incomes under $25,000 while 13.1% of households had incomes in excess of $100,000. This shows an increase in lower income households from 2000 when 27.4% had incomes less than $25,000. The percentage of wealthier households increase during this period from 12.7% in 2000. This pattern reflects growing numbers of households at both ends of the economic spectrum. Data is not yet available to reflect the economic upturn that began to emerge in Georgia in 2004.

Poverty: A total of 1,125,000 individuals in Georgia had incomes below the poverty level in 2003 ($18,400 for a family of four). There were 183,400 households with children under the age of 18 living in poverty; of which 39,000 households were those with children under the age of five only. Of the state's poor households, 158,700 were female headed households with children under the age of 18, and 26,600 of them were children under five years only. Looking at children in Georgia, 18.4% of all children under the age of 18 (approximately 400,000) were living in poverty in 2003 as compared to 18% in 2000. This is higher than the national poverty rate for children under age 18 of 17.6%. For children under the age of five, 21% were living in poverty in 2003 compared to 18.7% in 2000. Based on these numbers, Georgia ranked 22nd highest in children 18 and under living in poverty in 2002.

Health Economics: Health economics is a reflection of the overall economy. Georgia's general economy has had a number of impacts on its health system. With the collapse of the technology bubble beginning in 2000 followed quickly by the events of 9/11, the very industries that fueled Georgia's spectacular growth through the 1990s – technology, transportation, retail, conventions and tourism – fell on hard times. Metro Atlanta, with about 60% of the state's jobs and which exemplified the vibrant growth seen nationwide in the 1990s, was particularly hard hit. The job losses in Georgia were highest in the country during the early 2000s economic downturn. For example, the technology industry in Atlanta shrunk by about 20%; the construction industry by 17.5%; and the transportation industry by 9%. As a result, in 2002 the ramifications of the sinking economy began to be felt with state tax collections contracting by 5.2% during the early part of the state's fiscal year while corporate income taxes plunged 38%. These revenue declines continued through August 2003, resulting in cuts to state agency budgets, including the Department of Human Resources and its Division of Public Health and the Department of Community Health, the state's Medicaid and CHIP agency. The increase in tax revenue collections that continued since that time has blunted further what could have been even worse cuts for these agencies.

On a personal level, huge numbers of individuals lost jobs, often losing health benefit coverage at the same time. These former workers and their families, in many cases, sought care from safety net providers and/or the insurance medical coverage from public programs such as Medicaid and CHIP. Yet, these programs were incurring cuts at the very time that increased demands were being placed on them. These demands were magnified by inflation driving up the

costs of providing health care services. Also, as companies searched for ways to deal with declining revenues and increasing health insurance premiums, they began limiting the range of benefits offered, while increasing the cost of health cost premiums and co-payments for their employees. Health insurance premiums in Georgia grew at a rate three times faster than average wage earnings from 2000 to 2004. As a result, the cost of family coverage became prohibitive for many workers and their spouses and children were left without insurance. As the state began to emerge from its economic crisis, many of those who had lost jobs have returned to the work force but in positions, particularly in the service industry, that offer far fewer health benefits than their previous jobs.

Health care spending is a significant driver in Georgia's overall economy. The total expenditure for all personal health care in the state in 2001 was an estimated $76.4 billion, representing almost 11% of the overall state gross economy. Public health spending represented over $5 billion of this amount. Health care spending is continuing to grow at a rapid rate greatly exceeding inflation, although this has slowed somewhat in the past two years. Of the dollars spent, the most is spent on hospital care (over one-third) followed by physician services (about 30%), and prescription drugs (over 12%). For example, the total spending on retail prescriptions reached $490 million in 2003, an increase of .5% over the previous year, ranking Georgia spending as 11th highest nationally. While the state's population grew by 30% between 1988 and 2000, health services employment grew 106%. This net per capita growth of 58% in health services sector employment was almost three times the national growth rate. Beyond the actual dollar expenditure, other economic-related dynamics internal to the health system also shape Georgia's health delivery system.

Georgia ranks ninth nationally in the total number and 14th percentage-wise (16.4%) in uninsured residents. The number of non-elderly Georgians without health insurance at some point during the two-year period has risen by 431,000 from 1999-2000 to 2003-2004, an increase of 20%. Nearly one out of three non-elderly adult Georgians went without health insurance for all or part of this period. Of the Georgians uninsured during this latest two-year period, 1,575,000 people, 61% were without health coverage for six months or longer. The vast majority of these individuals were workers or members of working families (78.7%). Racial and ethnic minorities were disproportionately uninsured; 25.3% of White non-Hispanics, 40.4% of Black non-Hispanics, and 62.9% of Hispanics respectively were uninsured for six months or longer. In the most recent statistics (2002), 963,000 adults, about 18% of Georgia's population, were currently uninsured. The disproportionate impact on racial and ethnic groups is reflected with 13% of Whites, 25% of Blacks and 29% of Hispanics not having insurance. Those uninsured are also much more likely to be low income; 61.6% of the uninsured had incomes at or below 200% of the federal poverty level.

Rural areas of the state have the highest rates of Georgians under the age 65 without health insurance. The lowest percentage of uninsured is found in metro Atlanta (about 9%) while the highest percentage (about 25%) is found in south Georgia. The rate in metro Atlanta may be relatively low because it generally has higher incomes and more large employers that offer health coverage. More rural areas, south Georgia cited above, north Georgia (17%), and an area east of

metro Atlanta (20%), evidence lower health insurance coverage, possibly because of lower incomes and smaller employers.

Over two-thirds of Georgia's uninsured are either full-time workers or dependents of full-time workers. Children of low income full- and part-time workers often are not insured, even when the working parent has insurance. One particularly large group which has been covered by public insurance are the over 10,000 children of Walmart employees in Georgia who receive PeachCare (CHIP) benefits. The largest group of uninsured are men and women between ages 25 and 44. Women between age 55 and 65 are three times more likely than men in the same age group to be uninsured. One particularly vulnerable population is Georgia's rapidly growing number of undocumented residents. Uninsured Georgians report poorer health status than those with coverage as well as a decreased likelihood to have had a routine check-up in the past two years.

A strong relationship exists between the economy and health insurance coverage. The number of uninsured is affected by reduced overall income as seen in the decline of median income and the rise in poverty rates discussed above. Unemployment health care costs and employee share of health insurance premiums have all gone up while Georgia has been forced to cut Medicaid and PeachCare (CHIP) eligibility and coverage. These are contributors to the increased number of uninsured.

Over two million Georgians obtain health insurance directly through their employer and another two million dependents or spouses have coverage through an employer-sponsored plan. However, one in nine Georgians, about 400,000, are employed by firms that do not offer health insurance coverage. Almost all firms with more than 100 employees and 71% of those with ten to 24 employees in Georgia offer health insurance coverage yet only 35% of firms with fewer than ten employees provide health insurance. Approximately 73% of companies cite cost as the reason for not providing coverage. In the past year, health care expenditures by large employers in the Atlanta area grew at a rate of 10.6%, greater than the national rate. The average cost for these employers is now $7,089 per worker compared to $6,918 nationally. These companies had a higher percentage of workers enrolled in HMOs, 46% compared to 30% nationally.

Nearly 275,000 of Georgia's uninsured are children under the age of 18. Of these children, 196,000 are at or below 200% of the federal poverty level. This ranks Georgia fifth highest nationally in the number of uninsured children at or below 200% of the poverty level. Although Georgia specific data is not available, an analysis of the National Health Interview survey data reveals that CSHCN have different patterns of insurance coverage than other children, with more CSHCN having public insurance and fewer being without any insurance.

Recent focus groups conducted as part of the HRSA-funded Georgia Health Care Coverage Project assessed Georgians' attitudes and opinions regarding insurance coverage. The focus group findings indicated that Georgians are alarmed about the escalating cost of health care and believe that greed plays a major role. Most Georgians agree that everyone should get the health care they need but among higher income Georgians, a small but vocal group, who believe they will shoulder disproportionate costs, is less likely to agree. More so than the early 90s, Georgians are willing to consider universal coverage approaches and very willing to consider almost any

solution to address rising health care costs and increasing numbers of uninsured. Still however, Georgians place a high priority on their ability to choose their own physicians while acknowledging that some concessions may need to be made. They dislike managed care and perceive that the lower costs that were promised in return for restricted choices and increased access have not materialized. Questions are beginning to emerge as to whether the cost of having and using insurance coverage are worth the benefits.

Findings from these focus groups contributed to development of a statewide project involving local health care workers, business owners, and community leaders who are collaborating to develop an approach to deal with uninsured workers. A recently announced plan, using a "three-share" model, brings together employees, employers, and government to work together to cover the uninsured. It is a health collaborative where an administrative agency makes agreements with doctors and hospitals to care for the uninsured at a reduced rate. This model has been successfully employed in Michigan and Illinois. Georgia is being divided into four regions and the model is being adapted by community health care groups in each of these regions. The most significant challenge at this time is identifying the government funding, which would comprise the third share.

A third of Georgia's overall state budget is used to buy medical services for public employees and the poor. Medicaid spending in Georgia now exceeds ten cents out of each dollar of revenue, growing at about 12% annually, which is twice the rate of state revenue growth. Total state Medicaid expenditures are projected to be $2.0 billion in state fiscal year (SFY) 2006. When PeachCare for Kids (CHIP) began in Georgia in 1999, the total budget was $30 million with the state funds being approximately $8.5 million. By June 2004, the budget had grown to $285 million with Georgia paying $81.2 million. As a result, cost containment approaches, including Medicaid/PeachCare managed care, reduction of services, cuts in provider reimbursement, more stringent income eligibility requirements, and increased PeachCare premiums along with more severe penalties for non-payment, are being implemented in the state as discussed below in the health delivery section. This has already resulted in a slowing in the rate of Medicaid/PeachCare spending increases. However, huge infusions of state funds have been required to meet the growing costs and this has severely eroded the state's reserve fund. In response to implementation of these cost containment approaches, some providers are no longer accepting new Medicaid or PeachCare patients while others are choosing not to participate at all.

While Emergency Medicaid, which provides emergency services to undocumented residents, mainly childbirths, represents less than 3% of total Georgia Medicaid spending, costs related to it have increased by 349% from 2000 to 2002. This compares to a 44% increase in overall Medicaid spending during the same time period. A total of $58.1 million was expended in the budget year ending in August 2002 with care provided to 15,210 people.

The impact of rising costs is not limited to Georgia, but is national in scope. As a result, the federal government is seeking ways of controlling Medicaid, CHIP and Medicare costs, such as limiting state Medicaid "maximization," as well as shifting some of these costs to the states. The results of this effort are not yet known but potentially could have major fiscal implications for Georgia and the other states.

Georgia's hospitals directly contributed more than $10.6 billion to the state's economy in 2002 according to a Georgia Hospital Association report. During this time period, hospitals provided more than $917 million in uncompensated care. Ninety-seven out of the 165 hospitals in Georgia, 59%, had negative operating margins for payments for patient care services. Hospitals of under 150 beds have the highest loss per bed. Much of this negative cash flow is attributed to shrinking Medicare/Medicaid payments to the hospitals and the rise in the hospitals' annual liability premiums, ranging from 200 to 900%. Fewer than ten insurers are now writing malpractice insurance in Georgia. This rise in premiums particularly affects rural hospitals because they lack financial reserves to develop customized responses to these rates, such as self-insurance to cover increased deductibles.

From 1994 to 2000, the median medical malpractice award in Georgia rose from $362,500 to $1 million. This resulted in steep increases in liability and malpractice premium rates for hospitals and physicians. Thirty-eight percent of Georgia's hospitals saw malpractice premium increases in excess of 200% between 2000 and 2002. During the same time period, the average liability premium for physicians insured by the state's largest carrier went up 30%. In response to this, some rural hospitals have taken out loans to pay malpractice premiums, assuming greater out-of-pocket risks, increasing hospital charges, and eliminating services.

Physicians, particularly specialists, have seen their malpractice rates skyrocket. Thirteen percent of doctors reported having difficulty finding malpractice insurance and 20% changed insurers. From 2000 to 2003, family practice physicians experienced a 74% increase in professional liability insurance while OB/GYNs had a 56% rise. Some OB/GYNs and family practitioners have been forced to give up the obstetrical part of their practice and/or eliminate gynecological surgery. According to a recent study by the Georgia Board for Physician Workforce, one in three OB/GYNs planned to stop high-risk procedures because of the tort environment. One hundred OB/GYNs in Georgia have already stopped or will soon stop delivering babies. Physician Workforce data also indicates that the number of new doctors starting practices in Georgia has dropped by 55% in the two-year period 1994-1996 compared to 2000-2002, which has been partially attributed to the state's environment. At least 2% of Georgia's physicians, in the same study, indicated that they planned to leave clinical practice or the state within the next twelve months because of rising malpractice rates.

Georgia was labeled one of 12 crisis states identified by the American Medical Association as having some of the most dramatic increases in malpractice insurance. The pressures created by these increased premiums drove the passage of Senate Bill 3 in February 2005 by the Georgia State Legislature. This bill puts a cap of $1.05 million on non-economic damages, with a $350,000 limit on physicians and a $350,000 per facility limit on all medical facilities. The bill also provides that no physician or health care provider will be liable for a claim arising out of emergency care in a hospital emergency department, obstetrical unit, or surgical suite unless clear and convincing gross negligence can be proven.

Health Delivery System Environment: Georgia's health delivery system consists of four interconnected components: private providers, hospitals, community health clinics, and the

state's public health system which has two separate elements, the Medicaid/PeachCare payment system and the county public health services.

Providers: The 2004 Health Resources and Services Administration (HRSA) report, "State Health Workforce Profiles," shows Georgia's workforce status across a large range of professions.

Georgia Health Professional Summary, 2000		
Profession	**Number Employed**	**State Rank (of 50)**
Physicians	13,700	39
Psychiatrists	749	25
Physician Assistants	1,232	24
Registered Nurses	68,000	42
Nurse Practitioners	2,260	33
Certified Nurse Midwives	389	9
Licensed Practical Nurses	20,000	10
School Nurses	1,143	NA
Dentists	5,018	23
Dental Hygienists	4,760	23
Dental Assistants	5,160	47
Pharmacists	6,020	29
Psychologists	1,110	48
Social Workers	7,360	47
Physical Therapists	2,660	43
Occupational Therapists	1,790	35
Speech-Language Pathologists and Audiologists	2,020	42
Respiratory Therapists	2,520	20
Dieticians and Nutritionists	940	47
Home Health Aides	6420	48
Optometrists	820	12
Opticians	1910	22

*Reported number of dentists varies, based on reporting source.

Nearly 299,000 workers, 7.7% of Georgia's total workforce, were employed in the health sector in 2000. This ranks Georgia 37th among states in per capital health services employment.

There were over 13,700 active patient care physicians in 2000; 167 physicians per 100,000, ranking Georgia 39th among states in physicians per capita. Georgia had 56 primary care physicians per 100,000 compared to the national rate of 69 per 100,000. Georgia medical schools graduated 370 new physicians, ranking it 17th among states in the number of medical school graduates. However, on a per capita basis, Georgia graduated fewer new physicians per 100,000 population than the U.S. as a whole and ranked 34th among 46 states with medical schools in graduates per capita. There were 1,232 physician assistants practicing in Georgia; 15 per 100,000, slightly more than the national rate of 14.4.

In 2000, Georgia had almost 68,000 licensed registered nurses (RNs), of which 55,800 were employed in nursing. This resulted in a rate per capita of 679 RNs per 100,000, lower than the national rate of 780 RNs. Georgia had over 2,260 Nurse Practitioners, 27.5 NPs per 100,000 lower than the national rate of 33.7. With 389 Certified Nurse Midwives, Georgia had 4.7 per 100,000 population, higher than the national rate of 2.9. Georgia ranked 9th in Certified Nurse Midwives per capita compared to 2.9 nationally. About 20,000 Licensed Practical Nurses (LPNs) are found in Georgia, ranking the state 10th in the number of LPNs.

In the 2002-2003 school year, a survey of Georgia's 179 school districts indicated that 1,143 school nurses were employed. Of these, about two-thirds were RNs and one-third were LPNs. The overall state ratio of students to nurses was 1,287 students per nurse. However, the ratio in some of the largest school districts, such as DeKalb, Fulton, Gwinnett, and Muscogee, ranged upwards from 5,500 to 1 in Muscogee to 10,555 to 1 in DeKalb. Sixty-seven districts had a ratio of 750 to 1 or better and 14 districts had only an LPN and no RNs functioning as school nurses.

In the oral health workforce, there were 5,018 dentists, 4,760 dental hygienists, and 5,160 dental assistants practicing in Georgia in 2000. With 60.9 dentists per 100,000, Georgia had slightly lower than the national rate of 63.6, ranking the state 23rd in the nation in dentists per capita. The number of dentists in Georgia grew by 80% between 1991 and 2000, while the state's population grew by 24%. The 45% increase in dentists per capita in Georgia was significantly higher than the 16% increase in the U.S.

Among those providing mental health services, Georgia had 749 psychiatrists, 1,110 psychologists, and 7,360 social workers in 2000. While Georgia ranked in the middle (25th) among states in psychiatrists per capita, it ranked at the bottom in psychologists (48th) and social workers (47th).

The demand for health professionals in Georgia is projected to grow by 37% by 2010. The Georgia Department of Labor predicts a need for more than 140,000 new and replacement health care professionals, including about 30,000 additional RNs, 9,000 LPNs, 3,700 pharmacists, and thousands of allied health and behavioral health professionals. Vacancies in nursing and allied health professionals continue to be experienced by hospitals and long term care providers in Georgia, although there has been some improvement in the ability to fill positions. Vacancy rates ranging from 10 to 15% are being reported for nursing and selected allied health staff.

The state's physician supply has remained stagnant despite the rapid growth of Georgia's population. This trend may be come even more pronounced as Georgia's physician workforce is aging. Baby boomers now comprise 75% of the workforce and a significant portion of the state's physicians could retire in the next ten years. Georgia has experienced considerable growth in most primary care specialties over the last decade, however, challenges related to the geographic distribution of physicians remain. For example, the rate of pediatricians is 8.7 times greater in the MSAs than non-MSAs. The rate of OB/GYNs is six times greater in the state's MSAs than non-MSAs and the rate of family practice physicians is 3 times greater in MSAs than

non-MSAs. A total of 1,650 family practice physicians, 1,348 pediatricians, and 973 OB/GYNs practiced in Georgia in 2002.

Georgia's shortage of nurses has worsened with the shortage growing 38% from 1999 to 2001. In metro Atlanta, the shortage of registered nurses was 14.9% with the statewide vacancy rate running 13.3%. The highest vacancy rate was in the east Georgia Augusta area that experienced a 19.3% shortage. Exacerbating the problem is the decreased enrollment in Georgia nursing programs that fell from 15,000 students in 1993 to 8,000 in 2001. However, in 2002 for the first time in ten years, nursing education programs showed a growth of 50% over 2000 enrollment. A similar trend in graduation rates in other allied health programs has also been seen.

A more profound shortage has been experienced in relation to public health nursing. The total number of public health nurses in Georgia dropped from 1,793 in SFY 2003 to 1,669 in SFY 2004. This loss of 124 nurses represents a 6.9% decrease in the public health nursing workforce. Each health district lost, on average, 6.5 nurses. Low salaries have impeded nurses from applying for jobs in public health. Retention has also been a challenge for public health. After completing 9-12 months of on-the-job training in public health, many nurses leave for higher salary positions in the private sector.

Georgia's shortage of dentists is exacerbated by its maldistribution of dentists. Almost half of the dentists in Georgia practice in an eight-county metro Atlanta area that is home to one-third of the state's population. About 70% of all dentists practice in the northern part of the state, leaving many residents in the rest of Georgia having to travel great distances for dental care. A survey of practicing dentists in Georgia indicated that over 45% said they planned to retire within ten years. In the public health sector, recruitment and retention of oral health providers has been impacted by low salaries compared to salaries offered by the private sector.

Georgia's problem with maldistribution of providers continues to impact access to care, particularly for uninsured and underinsured persons and residents of rural areas, especially those requiring specialty care. There are too many providers in urban areas and not enough in rural parts of the state. Specialty care is more limited, generally located in areas with academic medical centers (i.e., Atlanta, Augusta, Macon and Savannah), leaving large portions of the state without access to this care. Moreover, the availability of providers to serve these populations is becoming even scarcer which has led to the designation of an increasingly large number of population groups for Health Professional Shortage Area (HPSA) status. Forty-two whole Georgia counties, and seven partial county service areas are currently designated by the federal government as primary care HPSAs as are 84 population groups. These population groups include those below 200% of the federal poverty level, Medicaid eligible individuals, and migrant farm workers within specific geographic areas. In addition, 117 whole counties and 48 partial counties are designated as medically underserved areas. Areas with dental HPSA designation include 27 whole counties, six partial counties, and 59 population groups. Mental health HPSA designation has been received by 44 entire counties as well as 43 service catchment areas.

Previous telemedicine efforts such as GSAMS have had limited success in bringing specialty care to areas of the state lacking these services. The state Department of Insurance, working with BC/BS of Georgia, is developing a statewide telemedicine network connecting at least 36 rural hospitals to Atlanta-based specialists. BC/BS has made a three year $11.5 million grant to fund equipment and staff in the these rural hospitals. They have made a commitment to reimburse telemedicine procedures, a major barrier in past efforts, and estimate that $5 million annually in claims will be paid. This network is being facilitated by recently enacted House Bill 291.

Hospitals: Georgia has 149 acute care hospitals. Of these hospitals, 39 (26%) have fewer than 50 beds. In total, these small hospitals in the rural parts of the state have 7% of all Georgia hospital beds. Another 45 hospitals have 100 or fewer beds. These hospitals represent 13% of the overall total hospital beds in the state. At the other end of the spectrum, 38 acute care hospitals have greater than 200 beds. These large hospitals, which constitute just over one-third of all facilities in the state, have about two-thirds of all beds. Fourteen of these 38 hospitals are located in the core metro Atlanta counties.

One critical aspect of the hospital-based delivery system is the availability of trauma and emergency care. Following the trauma hospital center redesignation process this past year, 14 facilities in the state are designated as trauma hospital centers: four Level 1 (highest level of care), nine Level 2 including two pediatric facilities, and one Level 3. Ten of the 14 trauma hospitals have pediatric beds, with a total of 728 beds including two children's hospitals, Children's Healthcare of Atlanta (CHOA)-Egleston and CHOA Scottish Rite. The trauma facilities are primarily clustered around metro Atlanta, Augusta, Columbus, Macon, and Savannah, leaving huge gaps in the state for persons requiring timely, quality trauma care. Another issue affecting trauma care is the lack of direct dial 911 in 21 counties in south and middle Georgia, areas traversed by I-75, I-20, I-16, and I-95. The lack of facilities and the ability to rapidly get trauma patients to quality definitive care during the initial "golden hour" impacts patient survival and outcomes. Another issue related to emergency care is the extent to which emergency departments are "on diversion," meaning ambulances must find alternative treatment facilities. This has evolved from an intermittent situation to an expected one, with hospitals in metro Atlanta on diversion every day of the year and hospitals elsewhere in this situation more and more often. For instance, early in 2005, during the flu outbreak which was not a particularly severe one, many emergency rooms in the rural southern part of the state went on diversion and lacked beds to admit patients.

Sixty-seven rural hospitals are eligible for Critical Care Access designation. To date, 35 hospitals have been designated with four hospitals receiving this designation in 2004. This federal program raises Medicare reimbursement rates for eligible facilities and provides cost-based reimbursement from Medicaid and the Georgia State Health Benefit Plan for outpatient services in return for agreeing not to: 1) operate any more than 25 beds, 2) team with a larger facility to deliver inpatient care, and 3) limit inpatient care provided to an average of no more than 96 hours.

The major hospital system upheavals seen during the late 1990s and early 2000s, which resulted in the closing of 15 hospitals since 1998, have abated. Presently, hospitals are positioning

against each other in population growth areas to provide revenue positive services. The only recent hospital closing was Southwest Hospital and Medical Center in Atlanta, which was one of about five hospitals nationwide controlled or operated by African Americans. This 125-bed hospital closed in January 2005. However, efforts are underway to reopen this facility. The only other recent hospital closure occurred in 2003 when Emory Parkway Medical Center in Douglas County, a 256-bed hospital, closed. Threatened closings that did not occur were faced by Boswell Memorial Hospital in rural northeast Georgia and South Fulton Medical Center in metro Clayton County. Since its threatened closing three years ago, this latter hospital has evidenced a remarkable turnaround.

Much of the hospital growth and major expansions are occurring in the surrounding suburban areas of metro Atlanta. After more than a decade of controversy about plans to build a facility in south DeKalb County in metro Atlanta, DeKalb Medical Center will open this 100-bed facility in summer 2005. In affluent north Fulton, Emory Johns Creek, a 110-bed hospital, is being built through an Emory/Health Care of America joint venture. This facility faced major opposition by six other hospitals serving that region, but after a prolonged court battle construction was started. Controversy also surrounded the expansion of Henry Medical Center in the south metro area. After facing opposition from both Southern Regional Medical Center and Spalding Regional Medical Center, an agreement was reached which will allow Henry to add 71 beds in a county which is the nation's third fastest growing. Other hospitals adding beds in metro Atlanta include Gwinnett Health System which won approval to add 107 beds, Northeast Georgia Medical Center, which is increasing by 30 acute care beds in Gainesville, and WellStar Kennestone Hospital, which is adding 30 medical/surgical and intensive care beds which will give the hospital a total of 633 beds, second in the state only to Grady Memorial Hospital. Also included are WellStar Douglas, which is embarking on an expansion and renovation, Rockdale Hospital, which is adding 31 new beds including expanded maternity and intensive care services, and Fayette Community Hospitals, which plans to open a 7-bed obstetrics unit. The need for Fayette's obstetric capacity is illustrated by the fact that hospital officials indicate they have delivered more than 25 babies in their emergency room and hospital parking lot because women arrive in labor expecting that the hospital has obstetric services. Fayette is one of the last counties in the state with a population greater than 100,000 that does not have OB services. Northside Hospital-Forsyth, whose flagship hospital Northside delivered more than 18,000 babies last year (more than the entire state of Maine), has obtained permission to offer obstetric services at their facility in Forsyth County. The facility will function as a Level II neonatal unit. Newnan Hospital in Coweta County has purchased its cross-town competitor Emory Peachcare Regional Hospital, becoming a two-campus hospital system. Piedmont Hospital in Atlanta is buying small 35-bed Mountainside Medical Center in the north Georgia mountains.

Between 2002 and 2007, metro Atlanta is projected to have an additional 140,000 children, the fastest growing pediatric population in nation. This has given rise to a realignment of pediatric hospitals in the area. Following the creation of Children's Healthcare of Atlanta (CHOA) in 1998, which brought together two major pediatric hospitals, Emory-Egleston and Scottish Rite, a further realignment of pediatric hospital facilities is taking place. The CHOA system has about 65% of inpatient pediatric visits in metro Atlanta. To deal with the demands on its system and its frequent operation at over capacity, CHOA is planning a $344 million expansion. This

expansion will add 70 beds to the CHOA system and expand emergency room capacity at both hospitals. Grady Health System's 82-bed Hughes Spalding Children's Hospital feared that this expansion would result in the closing of Spalding, serving low-income minority children in downtown Atlanta, and vigorously protested CHOA's plans. CHOA met this challenge by agreeing to put at least $15 million into renovations of the 52-year old Spalding facility and a commitment to fund the first $2 million of the estimated $8 million in losses that Spalding is experiencing. CHOA will also lead a community-wide effort to keep Spalding in operation. The funds at Spalding will likely be used to expand its emergency department capacity, which has more than 50,000 visits annually. Many children served in the Spalding emergency department are victims of abuse and neglect.

The state's major health safety net with the largest public hospital in Georgia and the only Level III nenonatal intensive care unit in north Georgia, Grady Health System, has been facing enormous fiscal challenges. Under a new administration, in just 12 months during 2003-2004, Grady Health System reduced its nearly $60 million deficit by more than two-thirds, partially by increasing collections by $5 million a month by signing up more Medicaid and Medicare patients and improving billing. The price of prescription drugs was increased from 50 cents to $2, a fee for service was instituted for non-emergency uninsured patients living outside Fulton and DeKalb Counties, and these patients were strongly encouraged to seek medical care in their own county. Annual savings of $8.5 million were realized by laying off over 200 employees, and nurses were hired as Grady employees to replace more expensive temporary nurses. Another approach has been to increase the number of babies born at Grady which had dropped significantly since 1998 when 8,119 babies were born at Grady to less than 4,000 in 2004 as a result of Medicaid reimbursement changes. After successfully emerging from a two-year budget crisis, new issues related to proposed state cuts in Medicaid has forced Grady to examine even further reductions in services. Medicaid plays a particularly significant role for Grady as it provides 53% of its net revenues. More than half of its patients are covered by Medicaid and about 30% more are uninsured.

Community Health Centers (CHC): Georgia's CHCs offer a comprehensive range of primary health care and other services including around the clock care, acute illness treatment, prenatal care, well-child care, physicals, preventive services, health education, nutritional counseling, laboratory, x-ray and pharmacy services. Among persons served at the state's 38 CHCs, approximately 41% are uninsured and 34% are Medicaid recipients. Almost two-thirds are members of a minority group: 35% are Hispanic, 25% Black, and 4% Asian/Pacific Islander. Since FFY 2001, four CHC new starts have been funded, with two of them recently approved to start services in FFY 2006. In addition, during this period, services have been expanded by existing CHCs to sites in nine additional counties.

Medicaid/PeachCare for Kids (CHIP): The Department of Community Health (DCH) administers the state's Medicaid and State Child Health Insurance Program (PeachCare for Kids) programs. Georgia has over 800,000 enrollees under age 21 and 129,000 women 21 years of age or older in Medicaid and about 200,000 enrollees in PeachCare. Presently, services are provided through a gatekeeper model, Georgia Better Health Care, in which a primary care case manager authorizes patient services. In order to control escalating costs over the past several years, some

changes in eligible services and patient eligibility have occurred. The eligibility for pregnant women and infants was reduced in 2004, from 235% of FPL to 200% of FPL. The reimbursement rates for health providers and hospitals have also been reduced several times over the past five years. In an effort to control soaring drug costs, a formulary was put in place in 2003. PeachCare changes which went into effect in 2004 include a premium increase, a sliding scale for monthly premiums, ranging from $10 to $35 per child, based on family income, and a "lock-out" period for late premium payments that was set at 30 days in 2004 and lengthened to 90 days at the end of the year. As a result of these PeachCare changes, 45,000 children lost benefits in the latter part of 2004, although 28,000 later regained the benefits.

Despite these measures, adequate cost containment has not occurred and DCH decided to institute managed care for Medicaid/PeachCare enrollees. Bids have been received to provide these services in six regions of the state from about a dozen potential vendors. The Georgia Care Program will cover the following populations: low income families, transitional Medicaid, pregnant women (presumptive), pregnant women (Right from the Start) – RSM, RSM children, newborns, PeachCare for Kids, and women eligible for Medicaid due to breast and cervical cancer. The program will be phased in by region between January 2006 and January 2007. Each Care Management Organization (CMO), awarded a contract in a given region, will be responsible for both cost containment and quality of care based on meeting established indicators. CMOs will be responsible for providing all Medicaid/PeachCare services, which include physician visits, laboratory and diagnostic testing, and inpatient and outpatient hospitalization; mental health and substance abuse treatment; pregnancy related services; prescription drugs; dental and vision care serves to eligible populations; screening and preventive services to eligible populations; and durable medical equipment. Specifically excluded from coverage by CMOs are elderly and disabled individuals, medically fragile children, and foster children. For excluded Medicaid recipients who are non-institutionalized elderly and disabled individuals, DCH is instituting a Disease Management (DM) program that will provide disease management services for a range of conditions, including but not limited to: asthma, diabetes, coronary artery disease, congestive heart failure, hemophilia, chronic obstructive pulmonary disease, psychiatric disorders, other co-morbid conditions, and risk factors related to chronic illness. The institution of these two approaches, CMOs and the DM program, will have profound but yet unknown impacts on the current health provider, hospital, and public health and mental health service delivery systems.

A side effect of the move to Medicaid managed care will be the loss of DCH's ability to participate in the federal Upper Payment Limits Program, which generated about $464 million in federal funds for the state in 2004. To replace these funds, the 2005 legislative session passed House Bill 392, which creates a tax of up to 6% on HMOs operating in Georgia. However, it is not presently known if sufficient revenues will be generated by this tax to offset the loss of federal funds. Also, this tax will inevitably be passed back to HMO consumers in the form of higher premiums and/or medical providers in the form of lower reimbursements.

In addition to financial impacts resulting from proposed changes in the Medicaid/PeachCare system, funding may also be affected by federal actions related to current state Medicaid financing approaches. The federal government is reviewing the practice of fifteen states,

including Georgia, in using "recycled" federal money rather than state and local tax revenue to meet Medicaid match requirements. Pending the outcome of this review, a substantial payment back of funds is possible.

Public Health (PH): Service delivery in the state's public health system is carried out by 159 county boards of health. These boards of health are combined into 18 district units, ranging from one to 16 counties in size, and are overseen administratively by a district office that provides management services and programmatic support. Each district is led by a physician district health officer who reports to the state office of the Division of Public Health (DPH), Department of Human Resources (DHR). The county boards of health provide direct health care services, environmental health activities, and work with community partners in their county around issues of common concern.

As public health enters this new state fiscal year, several emergent issues will impact the local public health service delivery system. County grant-in-aid, which are state funds provided to each county health department to support overall operations, are being reallocated, based on more recent population figures. The original allocation formula, upon which grant-in-aid allocations have been based, was derived from 1971 population data. With the extraordinary growth, particularly in suburban Atlanta, this has created disparities where the per capita funds in some of the fastest growing counties are about one-fourth that of counties with less population growth. However, many of these suburban counties are encountering health challenges that were unforeseen when the formula was originally calculated. In addition, over the past five years, the total grant-in-aid funding has been significantly reduced to meet state budget cuts, which has compounded the disproportionate funding in some parts of the states. Moreover, the county boards of health are being confronted with the potentially significant but still unknown impact related to the implementation of Medicaid managed care. Approximately 25% of current county health department revenues are derived from Medicaid/PeachCare, and based on proposed partnerships between MCOs and local providers, much of these revenues may be diverted elsewhere. As a result, an in depth examination of the viability of county boards of health continuing to directly provide health services is underway.

Mental Health (MH): The Department of Human Resources also includes the Division of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD). MHDDAD has been undergoing significant restructuring, as a result of a transition from hospital-based to community-based services and budget cuts that began in 1993 with the passage of Senate Bill 100. This bill established a regional board structure to plan and oversee service provision by community service boards. These community service boards provide community-based mental health, substance abuse and developmental disabilities services to an estimated 180,000 Georgians each year at a cost of $500 million. Originally 19 regional boards were established. These boards were decreased to 13 in 1997 and to seven in 2003 and are presently being contracted to five, effective July 1, 2005. The community service boards within the regions have had very mixed success and after just over ten years, many of them are facing severe fiscal and service delivery problems. In addition, the service boards are confronting the same issues related to implementation of Medicaid managed care as are being confronted by county boards of health, as well as a rebidding of services by MHDDAD that will result in private providers offering

substantial services previously provided by the service boards. The current operating environment and structure of the state's public mental health service delivery system is being addressed by a DHR task force, which is charged with overall system reform. As these changes are occurring, the movement of services to the community continues. Notable expansions for which funds were allocated in the SFY 2006 budget are child and adolescent mental health services as well as funding for child advocacy centers and child adolescent crisis stabilization services.

Overview of the Maternal and Child Health Population's Health Status

In 1997, the Georgia DPH and March of Dimes Georgia Chapter published *The Challenge of Change: A Mid-Decade Look at Maternal and Child Health in Georgia.* The report served as a starting point to assess needs and create effective intervention strategies to improve the health of mothers and infants throughout the state. The recent DPH report ***Maternal and Child Health in Georgia Birth Through Age 5, 2004*** describes the progress Georgia has made in health of the state's mothers and children since the 1990s. Report findings and recommendations are described below, followed by the health status highlights from the FHB's 2005 MCH Needs Assessment.

Maternal and Child Health in Georgia Birth Through Age 5, 2004 Findings

The DHR DPH partnered with more than ten agencies, including the Governor's Council on Maternal and Infant Health, the four Georgia Healthy Start Initiatives, Healthy Mothers Healthy Babies Coalition of Georgia, the Georgia Public Health Association, and March of Dimes Georgia Chapter to produce the interactive report, *Maternal and Child Health in Georgia Birth Through Age 5*, available on compact disk. The report provides data and analyses of maternal and child health trends, highlights of successful programs, offers tools for advocates, and provides recommendations to improve health outcomes for mothers and young children. Identified trends that are creating challenges and opportunities for Georgia's health care delivery system include:

- Increasing growth and diversity of the state's population;
- Disparities in health;
- An economic downturn which has decreased the resources available for public agencies to meet the needs of an increasing number of families that require governmental services to obtain needed health care;
- Lingering child poverty (19.3% of the state's children);
- Changes in federal policy designed to increase insurance coverage for children;
- An ongoing need to close the gap in the number of uninsured in Georgia; and
- The downstream effects of welfare reform, including decreased Medicaid enrollment.

The report found that in the last decade, particularly in the last five years, Georgia has made enormous strides to improve the health of mothers and children. Successes have included reductions in the incidence of infant mortality, perinatal mortality, teenage pregnancy, and unintended pregnancies.

- The infant mortality rate decreased 10% from 9.4 to 8.5 infant deaths per 1,000 live births between 1995 and 2001.
- The perinatal mortality rate decreased 50% from 16.0 to 8.0 fetal and neonatal deaths per 1,000 live births between 1995 and 2001.

- The pregnancy rate among teens 15 to 17 years old decreased 33% from 66.2 per 1,000 in 1995 to 44.4 in 2001. For teens 18 to 19 years old, the pregnancy rate decreased 13% from 146.7 per 1,000 in 1995 to 127.3 in 2001.
- The percent of unintended pregnancies decreased from 47.5% in 1995 to 41.5% in 2000.

At the same time, PeachCare for Kids has continued to increase enrollment of uninsured children. In addition, more women in Georgia are finding access to prenatal care and learning to adopt healthy practices after pregnancy that promote the well-being of themselves and their children. Such progress has been possible, in part, due to innovative public health programs and interventions across Georgia such as Children 1st and Universal Newborn Hearing Screening and Intervention, supported by multisector, cross-disciplinary partnerships involving state and local agencies, private providers, and many others.

As the state continues to move into the 21st century, the report suggests that the challenge will be to enhance and protect the health of families while adapting to economic and policy trends affecting health and social welfare systems, insurance practices, and the availability of public and private resources devoted to strengthening maternal and child health. As Georgia's population becomes more diverse, the state will also face challenges in reducing ongoing racial and regional disparities in health and ensuring that innovative, culturally appropriate programs and best practices are disseminated to all populations, including those that are underserved, at-risk, marginalized, limited English proficient, or have special health care needs.

To meet these challenges and achieve new federal and state goals in maternal and child health, report recommendations for progress included the following:

Pre-pregnancy Health and Health Promotion

- Develop and sustain efforts to inform women and their health care providers about the importance of preconceptional health, including issues related to nutrition, mental and emotional health, the potential impact of oral and reproductive tract infections on birth outcomes, and the dangers of alcohol, tobacco, and drug use.
- Encourage preconceptional evaluation and counseling for women with pre-existing health conditions, such as diabetes or high blood pressure, and ensure that counseling addresses methods for controlling the condition and avoiding complications, including those that may arise during pregnancy.
- Integrate pre-pregnancy health promotion messages across all maternal and child health programs to reduce unintended pregnancies and improve comprehensive services for all women.
- Continue to support programs using multifaceted and coordinated approaches to provide youth with: a) clear, accurate, age-appropriate, and culturally appropriate health information; b) accessible and affordable teen-friendly comprehensive health services; and c) ample opportunity to learn and practice effective communication, negotiation, and refusal skills.
- Continue to promote smoking cessation among young adults and young people by identifying and eliminating tobacco-related health disparities among specific populations, eliminating exposure to secondhand smoke, and preventing youth initiation of cigarette smoking and use of smokeless tobacco.

- Continue to support efforts that encourage all women to engage in at least 30 minutes or more of moderate-intensity physical activity on most, preferably all, days of the week.
- Encourage coordination between the public and private sectors to ensure that all women, including pregnant women, are screened, referred, and treated for domestic violence.
- Strengthen programs designed to reduce unintended pregnancies among teens through use of community-level interventions that promote youth development such as structured service learning, mentoring, and skill development.
- Encourage interaction and positive relationships between youth and communities, schools, faith institutions, and businesses, particularly for youth who lack supportive families.

Prenatal and Maternal Health

- Ensure that all pregnant women have access to early prenatal care.
- Encourage coordination between the public and private sectors to ensure that all women are prenatally screened for HIV, STD, and bacterial infections, including Group B strep, with appropriate follow-up and treatment for the whole family.
- Enhance strategies to remove cultural barriers to care that may contribute to delayed entry into prenatal care.
- Provide pregnant women who smoke with access to smoking cessation classes, counseling and other aids to cessation.
- Support efforts to encourage women who were physically active before their pregnancy to continue such activity during pregnancy.
- Ensure that Medicaid-eligible and WIC-eligible mothers and their children served by public health departments have access to nutrition services provided by licensed dietitians.
- Encourage breastfeeding by targeting populations and areas in which initiation rates are low and by promoting education, counseling, and other forms of support for new mothers.
- Strengthen capacity to identify and investigate all maternal deaths, to improve the accuracy of maternal mortality data, and to ensure that lessons learned for preventing deaths are reported to health care providers.
- Expand efforts to address special needs of pregnant women to improve birth outcomes.
- Develop and implement a comprehensive statewide approach to address maternal depression and substance abuse.

Infant Health

- Implement strategies to decrease racial disparity in the incidence of infant mortality, low birth weight births, and sudden infant death syndrome (SIDS).
- Continue the *Georgia Infant Safe Sleep* campaign to reduce SIDS and other infant deaths through the promotion of "safe sleep" messages, crib safety techniques, and smoking cessation for pregnant women and new mothers.
- Implement CDC's recommended standard investigation of sudden unexpected infant deaths due to accurately differentiated SIDS from other unexpected infant deaths and to identify associated preventable risk factors.
- Explore feasibility of establishing a Fetal and Infant Mortality Review process in every county for investigating fetal and infant deaths, including statewide epidemiologic analysis of causes and frequency of presence of specific risk factors for fetal and infant deaths.

- Ensure access to preventive health services and health care for all children, especially those in state custody.
- Continue to develop the Georgia Birth Defects Reporting and Information System, in collaboration with the March of Dimes Georgia Chapter, for improved birth defects surveillance capacity.
- Continue to enhance Georgia's newborn screening programs, including metabolic, sickle cell, and hearing screenings.
- Fully implement the Georgia Registry of Immunization Transactions and Services (GRITS).
- Continue to support programs that increase parents' awareness of proper child safety seat usage and provide access to age appropriate child restraint devices as recommended by the American Academy of Pediatrics and the National Highway Traffic Safety Administration.
- Enhance knowledge among health care professionals, pediatricians, and parents about shaken baby syndrome, and increase parental awareness of effective coping skills for managing crying infants.
- Provide new mothers who have stopped smoking during pregnancy with continuing access to smoking cessation classes, counseling, and other aids to cessation.

Early Childhood Health and Development

- Continue to support efforts to identify and assess the needs of infants and children at risk for poor health and development, and promote referral of such children and their families to appropriate public health and community services or health care providers when needed.
- Ensure that families have knowledge of available health insurance options and health care services, including developmental screenings and anticipatory guidance.
- Update standards and guidelines related to preschool and school-age vision, hearing, dental, and nutrition screening to reflect current standards of practice.
- Encourage pediatricians and other health professionals to adopt the recommendations included in the American Academy of Pediatrics' "Policy Statement for Prevention of Pediatric Overweight and Obesity."
- Enhance skills of health care providers, including public health nutritionists and private physicians, to assess and provide appropriate health, nutritional, and developmental counseling to infants, children, and youth, including those with disabilities and chronic conditions.
- Ensure access to oral health education for low-income at-risk pregnant women, parents, and young children (ages four and above) in order to reduce the risks of low birth weight babies, early childhood caries, and other medical conditions correlated with chronic periodontal disease.
- Strengthen the capacity of Georgia's health care professionals and providers to protect and promote the good health, safety, and well-being of children.
- Encourage the elimination of environmental sources of lead to decrease the risk of lead poisoning, and continue blood lead level testing for at-risk children.
- Continue to support state programs that increase parents' and health care professionals' awareness and knowledge of environmental health hazards (i.e., lead, arsenic, mercury, and indoor air quality) that particularly impact children.

- Continue to enhance professional knowledge of social and emotional development in young children on topics such as typical social and emotional development of children birth to age 5, brain development, relationships between childcare and parents, child mental health concerns, and post-partum depression.
- Enhance the capacity of parents, educators, childcare providers, health care professionals, congregational leaders, and children to promote the building of developmental assets in young children.
- Continue to promote inclusion of children with special needs in environments with typically developing children.
- Provide parents of children with special needs information and support to facilitate their children's development.
- Collaborate with internal and external partners to train public health nurses to recognize child abuse or neglect in children, including those with disabilities and developmental delays, and to make appropriate referrals.
- Build and sustain a comprehensive early childhood system that involves the collaboration of service providers, families, communities, and policymakers, and strengthens comprehensive pediatric care services, creates a medical home, promotes social-emotional development of young children, builds early care and education, provides parenting education, and enhances family support.
- Through collaborative efforts, reduce deaths, hospitalizations, hospital emergency department visits, and activity limitations among children with asthma.
- Expand awareness of the "primary provider model" of early intervention service delivery for young children with disabilities.
- Continue to develop and disseminate public awareness materials to ensure individuals with disabilities have access to appropriate services mandated by federal laws.
- Continue to conduct outreach and training activities for pediatricians and family practitioners to increase identification and referral of children with special needs to appropriate services.
- Maintain efforts to improve developmental outcomes for low birth weight babies and their families.

Maternal and Child Health Services

- Support coordinated maternal and child health planning, particularly regional systems of care.
- Support Medicaid eligibility for pregnant women and children.
- Enhance access for women with high-risk pregnancies to deliver in regional tertiary centers that have appropriately trained staff and equipment needed to manage complicated births.
- Continue to identify and address barriers, lack of insurance, transportation, and appropriate, accessible childcare.
- Develop a well-integrated referral system between health care providers, child protective services, and women's services to effectively serve children and mothers who are victims or are at-risk of intentional injuries (violence against women, child abuse).
- Support efforts that emphasize healthy eating and active lifestyles for women and children to achieve and maintain healthy body weight.

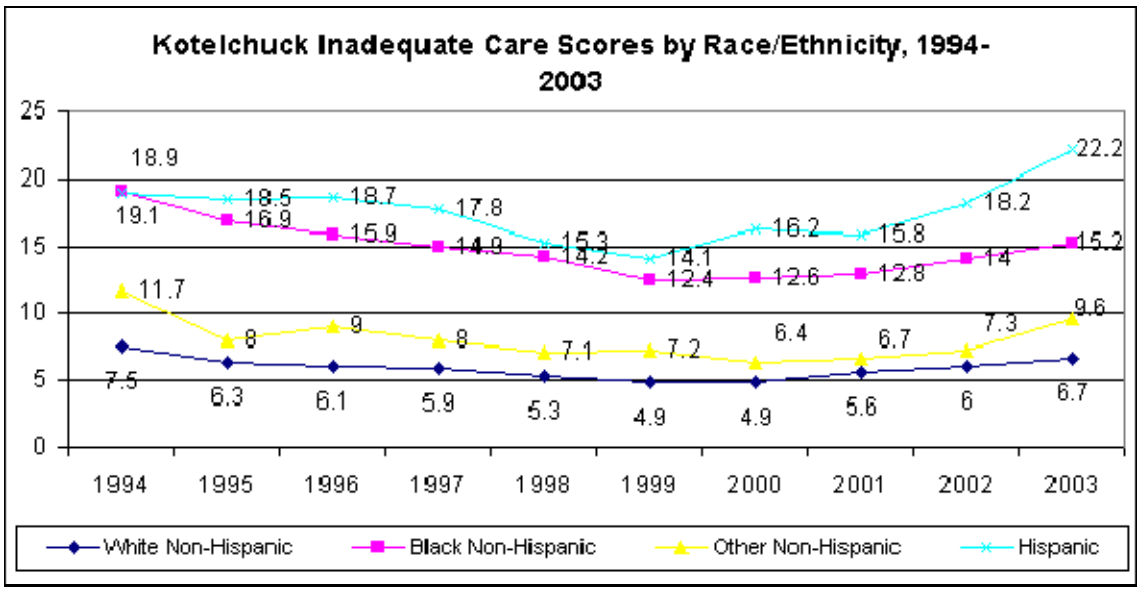
FHB MCH 2005 Needs Assessment Findings - The data below highlight relevant aspects of Georgia's MCH population, describing morbidity, mortality, risks, gaps and disparities.

Women's Highlights: Advances in public health have played a major role in increasing the life expectancy of women by nearly two-fold over the past century. The fact that women are living longer has created new public health challenges to improve the quality of women's lives as they age.

Reproductive Health and Birth Outcomes: Issues related to reproductive health have a dual impact, both on the mother and the infant. In 2003, the most recent year for which data is available, there were 135,831 live births in the state. Every day in Georgia, for example, on average:

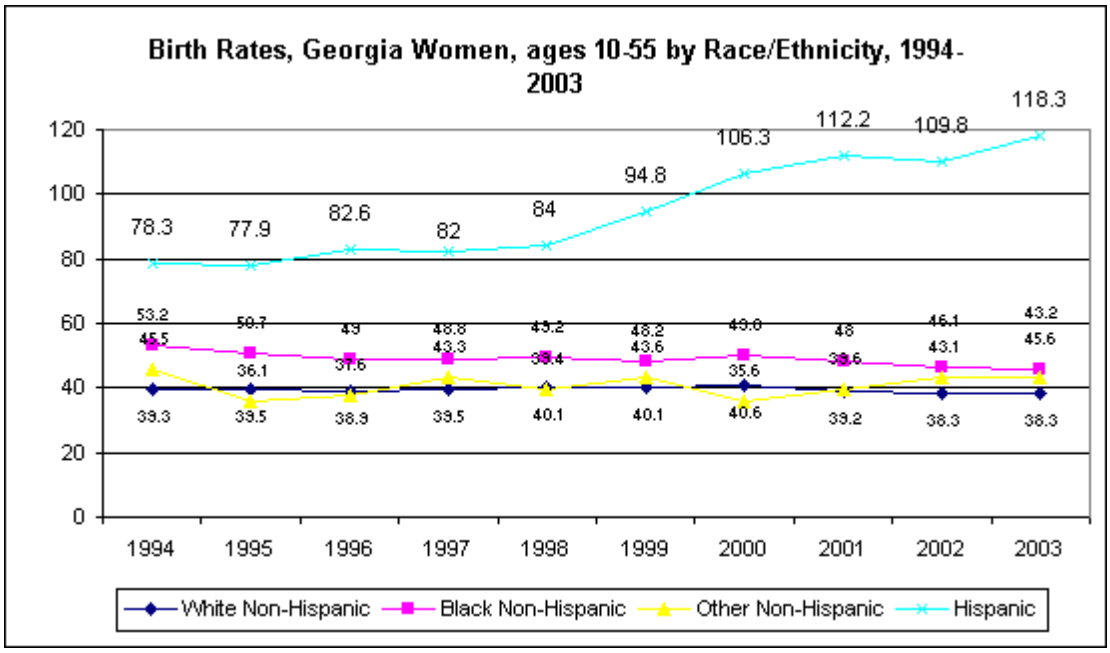
- 43 babies are born to teen mothers ages 15-19
- 43 babies are born to mothers who receive inadequate prenatal care
- 33 babies are born at low birthweight (less than 2500 grams)
- 6 babies are born at very low birthweight (less than 1500 grams)
- 49 babies are born preterm (less than 37 weeks gestation)
- 3 infants die before their first birthday

Prenatal care is a cost effective intervention that is associated with improved maternal and infant health. It includes regular medical visits during which the mother may be instructed about healthy habits both during and after pregnancy. Overall, the percent of Georgia women without adequate prenatal care decreased in the period 1994 – 2003; however, since 2000, rates among all groups have risen, with an increase of 17% for Hispanic women. Georgia ranks above the U.S. average of 83% of mothers beginning prenatal care in their first trimester, with 86% of all Georgia mother receiving care in their first trimester in 2001.



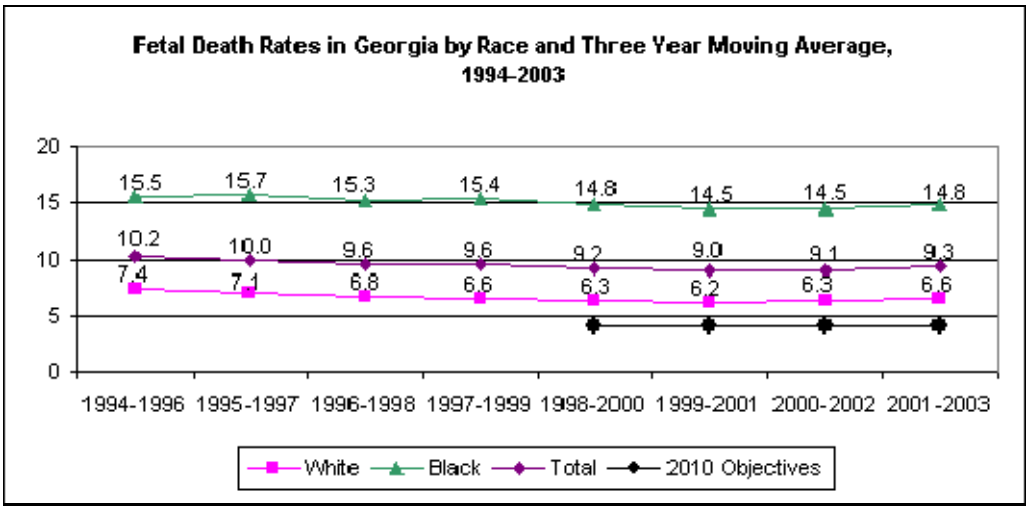
Data source: http://oasis.state.ga.us/webquery/mch.html

While the **birth rates** among all non-Hispanic women remained relatively constant over the ten-year period from 1994 to 2003, the birth rate among Hispanic women increased by 51%.



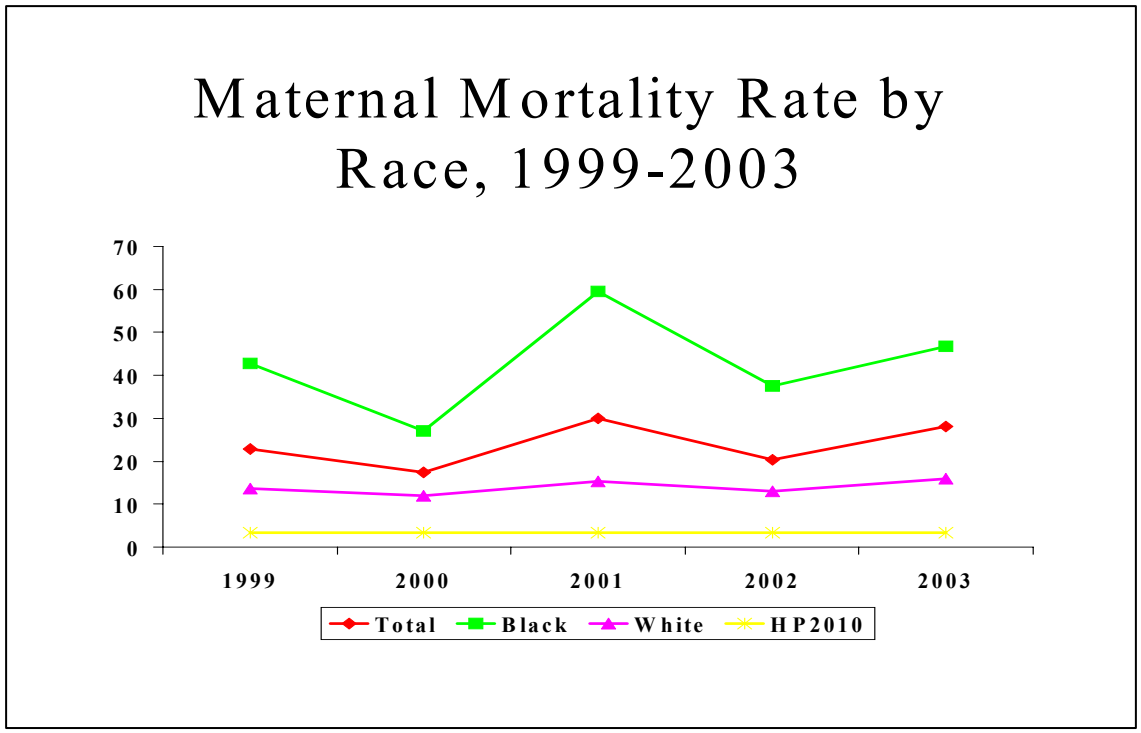
The 2003 preliminary U.S rate is 66.1 (ages 10-54)
Data source: http://oasis.state.ga.us/webquery/mch.html

The rate of **fetal deaths** has decreased over the ten-year period 1994-2003 by 10.8% in Whites and by 4.5% in Blacks. The rate of Black fetal deaths, however, is consistently over twice that of Whites. White fetal death rates have steadily decreased, while Black fetal death rates have been less consistent in their decline, which contributes to a gradual increase in the ratio of Black fetal deaths to White fetal deaths. However, the rates have begun to increase again over the last few years. Healthy People 2010 objective 16-1 for reducing fetal deaths at 20 or more weeks of gestation sets a target of 4.1 fetal deaths per 1,000 live births. The Georgia rates of fetal deaths in both Whites and Blacks have been significantly higher than the 2010 target rates.



Data source: http://oasis.state.ga.us/webquery/mch.html

Despite dramatic declines in **maternal mortality** since the beginning of the 20th century, rates have not declined since 1982 in the U.S. In 1996 (the last year with national data available), Georgia's pregnancy associated mortality rate was the 4th highest in the U.S. The maternal mortality rate among black women is about three times that for white women in Georgia. In 2002, the rate for black women was 37.5 per 100,000 live births compared to rate of 12.9 for white women. Neither group has reached the Healthy People 2010 goal of a rate of 3.3 per 100,000 live births.



Data source: Maternal Mortality Surveillance, MCH Epidemiology Section, Epidemiology Branch, Georgia Division of Public Health

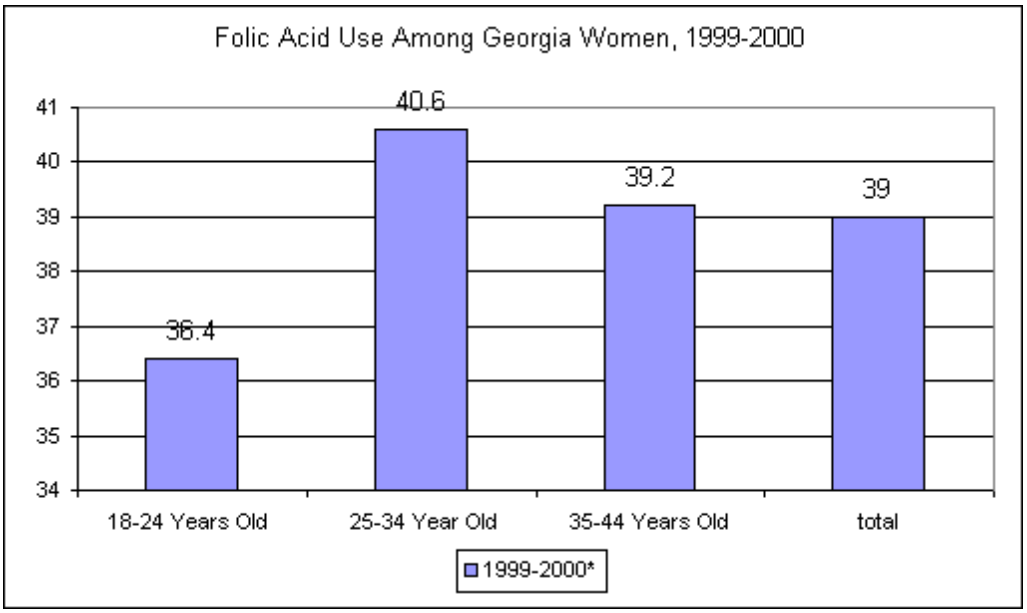
Pregnancy Related Issues: Unplanned pregnancy continues to be a problem for women in Georgia. Nearly half (47%) of Georgia women reported that their pregnancy was unintended, 34% wanted to be pregnant later, and 13% did not want to be pregnant at all. About 62% of women whose births were covered by Medicaid and 28% of women whose births were covered by private insurance reported that their pregnancy was unplanned.

Some health concerns are exacerbated during and immediately after pregnancy. These include antenatal and postpartum depression and domestic violence. Twenty percent of women experience depression at least once during their lifetime with the primary reproductive years (ages 25-44) being the time of peak incidence. Based on the BRFSS, the percentage of women reporting frequent mental distress almost doubled between 1997 and 2001 from 8.1% to 15.7%. Postpartum depression is a complication seen in 10 to 15% of all deliveries. With the increase in the number of babies born in Georgia, this condition is affecting a greater number of new mothers.

Thirty percent of women of reproductive age in Georgia have indicated that they experienced domestic violence during their lifetimes and about 6% experienced domestic violence during the past year. Of these latter women, 63% reported physical injuries. Previous studies have indicated a spike in domestic violence during pregnancy and immediately following. During the first 11 months of 2002, over 67,000 calls were made to domestic violence crisis lines in Georgia, an increase of 5,000 calls for calendar year 2001. Data has shown an increase in the number of domestic related homicides in Georgia in recent years, with a particularly high number in Gwinnett County where the number of protective orders is almost double those in Fulton County, which has a larger population, and triple those in DeKalb and Cobb, whose population is similar.

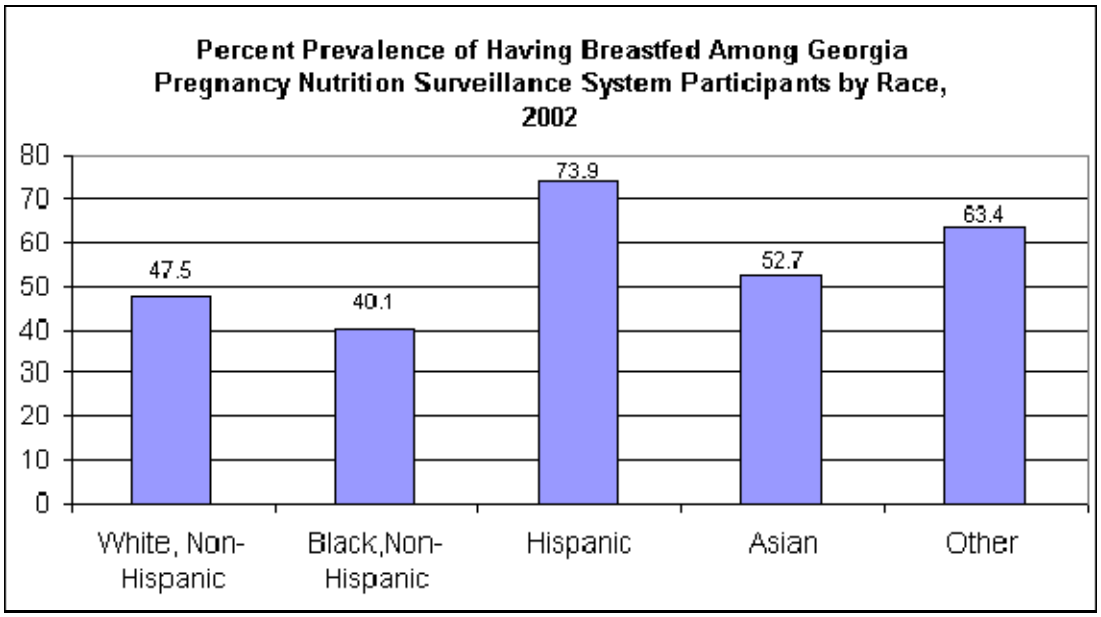
Perinatal infections are of great concern because of their ability to cross the placental barrier. Following the institution of ACOG and AAP guidelines in 2002, rates for early onset Group B Strep have dropped in a 20 county metro Atlanta area to the level of Healthy People 2010 objectives. While over 90% of women giving birth in metro Atlanta are screened for syphilis, approximately 5% who are not screened are from disproportionately high risk populations. Overall, the number of reported congenital syphilis cases in Georgia has declined, dropping from an average of about 20 per year in the late 1990s and earlier 2000s to only five cases in 2004. (*Maternal & Child Health in Georgia Birth Through Age 5 2004* Report, Division of Public Health, Georgia Department of Human Resources)

Health Promoting Behaviors: Adequate pre-pregnancy **folic acid consumption** has been shown to be important in reducing the risk of neural tube defects. In 1999-2000, only 39% of Georgia women of all ages reported daily use of folic acid and 63% of Georgia women were not even aware that folic acid is recommended to prevent birth defects.



Data source: http://health.state.ga.us/pdfs/epi/brfssreport.02.pdg

Breastfeeding offers significant advantages over bottle feeding for both mother and baby. Among Georgia's WIC population, breastfeeding prevalence is lowest among Black non-Hispanic women and highest among Hispanic women.



Data source: http://health.state.ga.us/pdfs/publications/reports/pnss.report.02.pdf

Preventive health practices among women include screening for breast and cervical cancer. Early detection increases the chances of long-term survival for women in whom a cancer is detected. In Georgia, 94.4% of women have received a Pap smear (based on the 2002 BRFSS); 85.7% of women over the age of 40 have had a mammogram in their lifetime with 70.2% of them having had a mammogram in the proceeding two years; and 90.3% of all women having ever had a clinical breast examination. These data rank Georgia 6th in the U.S. in percentage having had Pap smears and 20th in having had a mammogram in the past two years. A recent DPH survey found that the main reason some Georgia women do not get screened for breast and cervical cancers is because they do not know they should. Other reasons given for not getting screened were lack of health insurance, relying on their medical providers to tell them they needed to be screened, and believing that they were not at risk for cancer.

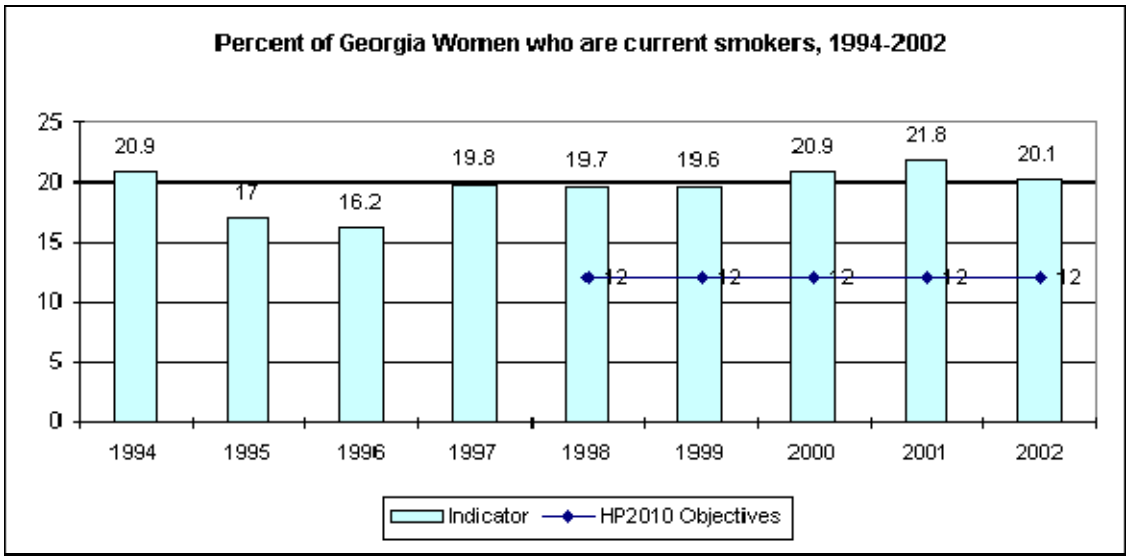
Health Risk Behaviors: **Sexually transmitted diseases** (STD), beyond being a problem in themselves, are indicative of unsafe sexual practices that result in unplanned pregnancies. High sexually transmitted disease and HIV rates, especially in minority females, threaten fertility, pregnancy outcomes and general quality of life in a number of Georgia counties. Georgia consistently ranks among the top five states for chlamydia, gonorrhea, and syphilis, and residents of the metro Atlanta account for over half of the state's STD cases. Women and African Americans are disproportionately affected by STDs generally and by chlamydia specifically. Chlamydia is the most common reportable STD in Georgia (29,148 reported cases in 2003). Approximately 85% of women and 40% of men have no symptoms. Gonorrhea is the second most common reportable STD (9,193 reported cases in 2003.)

Recent HIV/AIDS data reflect the disproportionate impact of this epidemic on the state's African American population in particular, and on women in general. Adult and adolescent women account for 18% of all diagnosed AIDS cases in Georgia. Almost 60% of all women with AIDS in Georgia live within the 20 county metro Atlanta Eligible Metropolitan Area (EMA). African Americans represent 83% of all AIDS cases among women in the state. Most adult and adolescent women with AIDS reported their exposure risk as heterosexual contact (39% in Atlanta EMA and 45% in Georgia) or injecting drugs (30% in EMA and 23% in Georgia).

Health Risk Behaviors – STDs, AIDS Number of Reported Cases in Georgia Females, All Ages					
Health Condition	**1999**	**2000**	**2001**	**2002**	**2003**
Chlamydia	25,588	25,360	27,165	28,168	29,148
Gonorrhea	10,439	9,793	9,323	9,512	9,193
Syphilis – Secondary	131	130	109	83	65
Syphilis – Other	353	330	375	284	309
AIDS	356	353	357	381	445

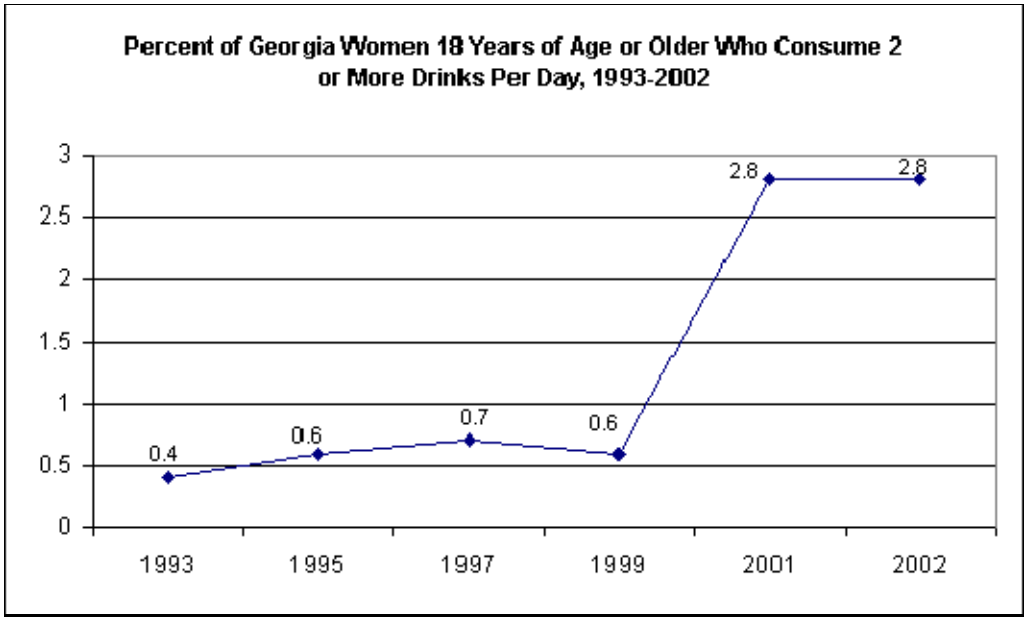
Data source: http://oasis.state.ga.us/webquery/mch.html

The use of **tobacco, alcohol, and illicit drugs** present risks for all women, but during pregnancy, they are also significant risk factors for a variety of negative infant health outcomes. Twenty-one percent of American women smoke compared to 20% in Georgia. Among girls in grades 9-12, 27% of Georgia teens smoke compared to 28% nationally. The prevalence of smoking among Georgia women has decreased by 3.8% between 1994 and 2002, but is 67.5% higher than the Healthy People 2010 objective. Georgia women rank high nationally, 9th in the U.S., for abstaining from smoking during pregnancy. Among non-Hispanic White women, 87.1% abstain, with a significantly higher percentage, 95.4% of non-Hispanic Black women abstaining.



Data source: http://health.state.ga.us/pdfs/epi/brfssreport.02.pdf

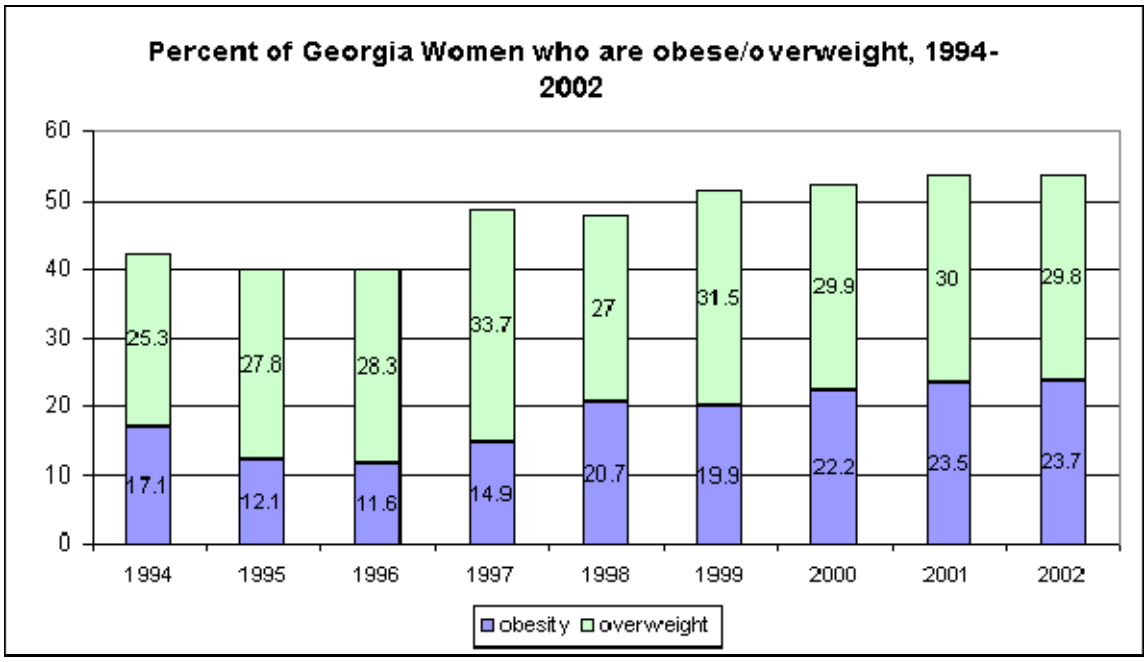
The percent of women consuming two or more alcoholic drinks per day increased from 0.4% to 2.8% during the period 1993 to 2002. However, Georgia women have among the lowest levels of binge drinking (five drinks in a row), ranking 9th nationally.



Data source: http://health.state.ga.us/pdfs/epi/brfssreport.02.pdf

Women in Georgia have some of the highest rates nationally of high blood pressure (44th in U.S.), obesity (40th in U.S.), and physical inactivity (42nd in U.S.), health factors that are associated with cardiovascular disease and stroke. Moreover, these three risk factors are found more frequently among the state's large minority Black female population than in Georgia's White population. The percentage of non-Hispanic White women diagnosed with high blood pressure is 24.1% compared to non-Hispanic Black women (38%).

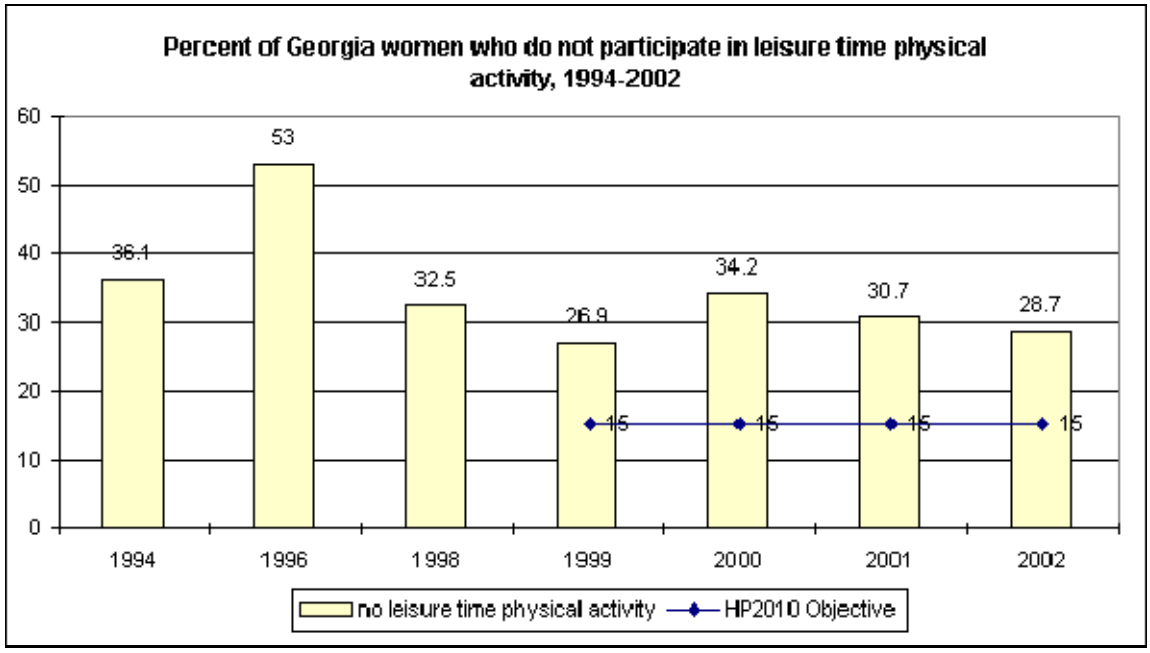
Overall, the prevalence of **obesity** among Georgia women increased by 38.5% between 1994 and 2002, from 17.1% to 23.7%. The prevalence of obesity among women is 58% higher than the Healthy People 2010 objective of 15%. The percentage for White women age 20 and over is 18.7% compared to Black women 35.8%. In 2003, Georgia ranked 6th in the U.S. for percentage of obese adults. Georgia spends $2.1 billion treating obesity, 6% of the state's overall health care costs. Obesity accounts for 10% of Medicaid spending in Georgia.



Healthy People 2010 objective: 15%

Data source: http://health.state.ga.us/pdfs/epi/brfssreport.02.pdf

Overall, the percent of women who do not participate in **leisure time physical activity** decreased by over 20% between 1994 and 2002, from 36.1% to 28.7%, but is still 91% higher than the Healthy People 2010 objective. Among non-Hispanic White women, 27.1% indicate they participate in no leisure time physical activity compared to 40.4 % of non-Hispanic Black women.

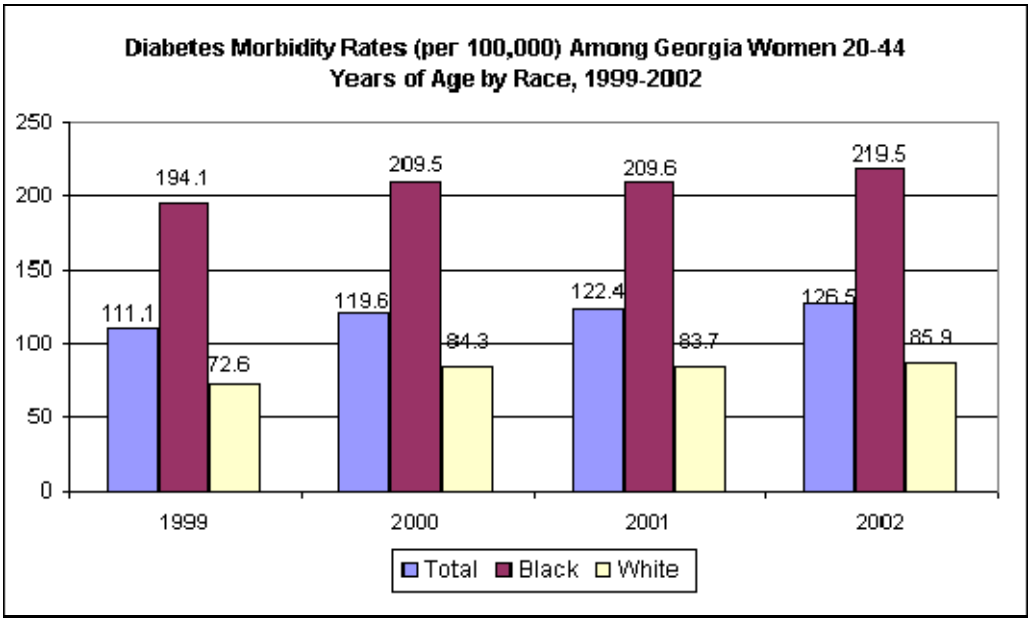


Data source: http://health.state.ga.us/pdfs/epi/brfssreport.02.pdf

Chronic Health Conditions: Four risk factors - high blood pressure, obesity, lack of physical activity, and tobacco use - are responsible for the majority of chronic disease experienced by women. The high rates of morbidity and mortality related to heart disease and strokes, cancer, and diabetes in Georgia can be directly attributed to the first three of these risk factors. The recent increase in tobacco use in females will over time become a significant factor as well.

Georgia ranks 3rd nationally in early deaths, those under the age of 65, caused by heart disease. Among women, Georgia ranks 24th worst in coronary heart disease mortality and 47th worst in stroke related mortality.

The prevalence of **diabetes** has increased substantially over the last decade, at an annual average increase of 8% a year. The prevalence of diabetes is higher in women than in men (7.4% versus 6.2%), and higher among Blacks than Whites (9.4% versus 6.0%). The prevalence of diabetes among Black women is almost twice as high as any other race/sex group. The state ranks 22nd worst in diabetes related mortality in women. The rate of people in Georgia being treated for diabetes, 7.1%, is above the national rate of 6.5%. Diabetes rates increased by almost 14 % for Georgia women ages 20 to 44, in a four year period between 1999 and 2002. The rate of increase for Black women during this period was 13% compared to an 18% increase for White women; however, the death rate from diabetes for Black women is more than two times higher than for White women.

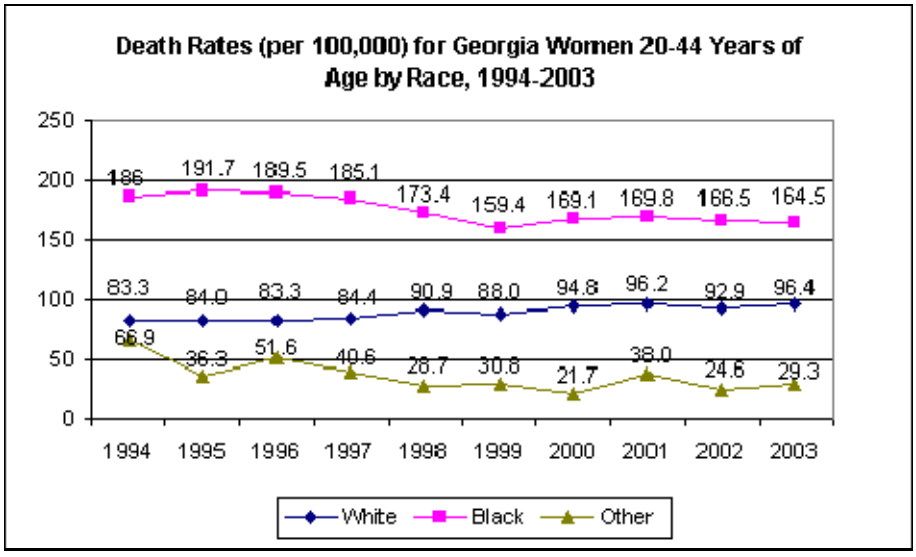


Data sources: http://oasis.state.ga.us/webquery/ddeath.html

Cancer mortality among females in Georgia ranks the state in the middle for major cancers: breast cancer 23rd in the U.S.; colorectal cancer 17th in the U.S.; and lung cancer 25th in the U.S. Overall, breast cancer death rates have decreased between 1990 and 2000, but the mortality rate among Black women increased from 30.0 per 100,000 to 31.1 per 100,000. The breast cancer mortality rate among Black women is 36% higher than among White women. In the metro Atlanta area, this rate is 67% higher among Black women. These rates compare to the U.S. rate where breast cancer mortality rate among Blacks is 30% higher than Whites. Lung cancer deaths during the same period increased approximately 2 deaths per 100,000 among all race groups.

Adult and adolescent women account for 18% of all diagnosed AIDS cases in Georgia, with almost 60% of these women living in the metro Atlanta Eligible Metropolitan Area (EMA). From 1994 to 2003, 3,662 AIDS cases in women have been reported. Over this period of time, the number of cases reported each year has increased, going from 384 in 1994 to 425 in 2003. Black women represent 83% of these AIDS cases and AIDS is the leading cause of death in Georgia among Black women ages 20 to 44. In the Atlanta EMA, Black women also account for 25% of all HIV positive tests and have a 2% seroprevalence rate.

The **death rate among Georgia women** between 20 and 44 years of age fluctuated from 1994 to 2003, with the highest rates occurring among Black women. The death rate among Black women in this time period dropped from a high of 191.7 per 100,000 in 1995 to 164.5 per 100,000 in 2003. However, the rate among White women increased 15.7%, rising from 83.3 per 100,000 to 96.4 per 100,000 over the time period.

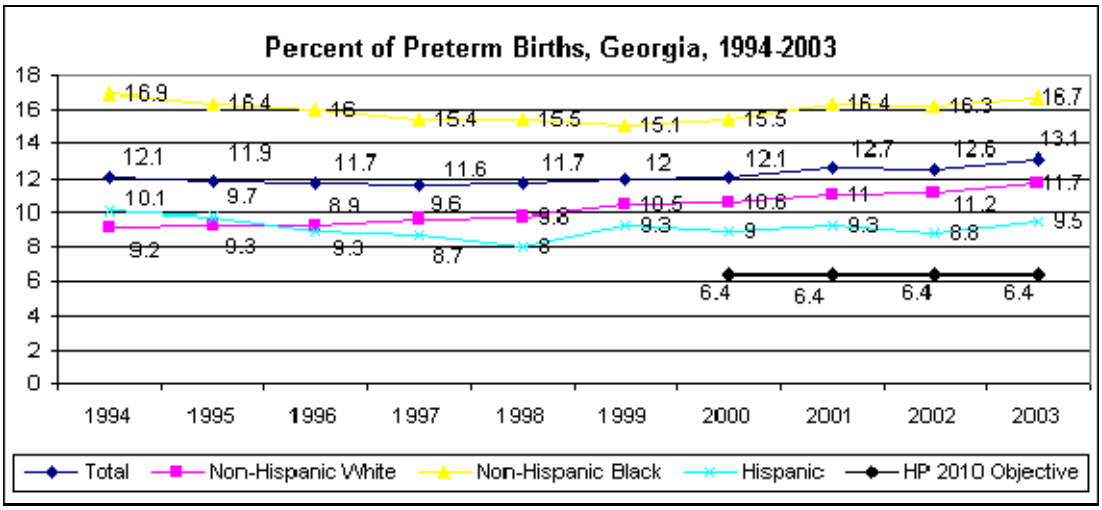


Data source: http://oasis.state.ga.us/webquery/death.html

Infant Highlights

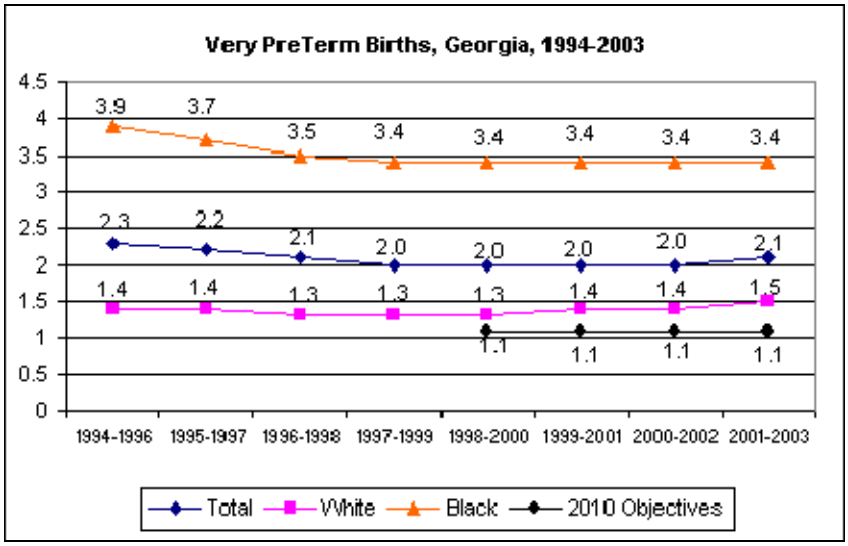
The birth of a healthy infant can be one of the happiest times for a family. However, the public health system alone cannot guarantee that each one of the more than 135,000 infants born each year in Georgia is healthy, receives appropriate services, and enters a stable home in which he/she is wanted. The indicators below provide an overview of the perinatal and infancy issues faced by Georgia infants and their families. Despite the significant gains that have occurred in the past decade, overall, infants in Georgia still do not fair as well as infants in the U.S. as a whole.

Birth Outcomes: With medical advances, the percentage of preterm and very preterm infants that are born and survive is increasing. The long term costs of caring for these infants, both in terms of health dollars and the impact on their families, is significant. Georgia leads the U.S. in the percent increase in premature births since 1992. While the percentage of preterm births among non-Hispanic Blacks has decreased slightly (1.2%) from 1994 to 2003, the percent of preterm births for non-Hispanic Whites has increased significantly (27.2%) in this time period. Overall, the percentage of preterm births in Georgia has increased by 8.3%, rising from 12.1% to 13.1% compared to the U.S. rate of 12.3%.



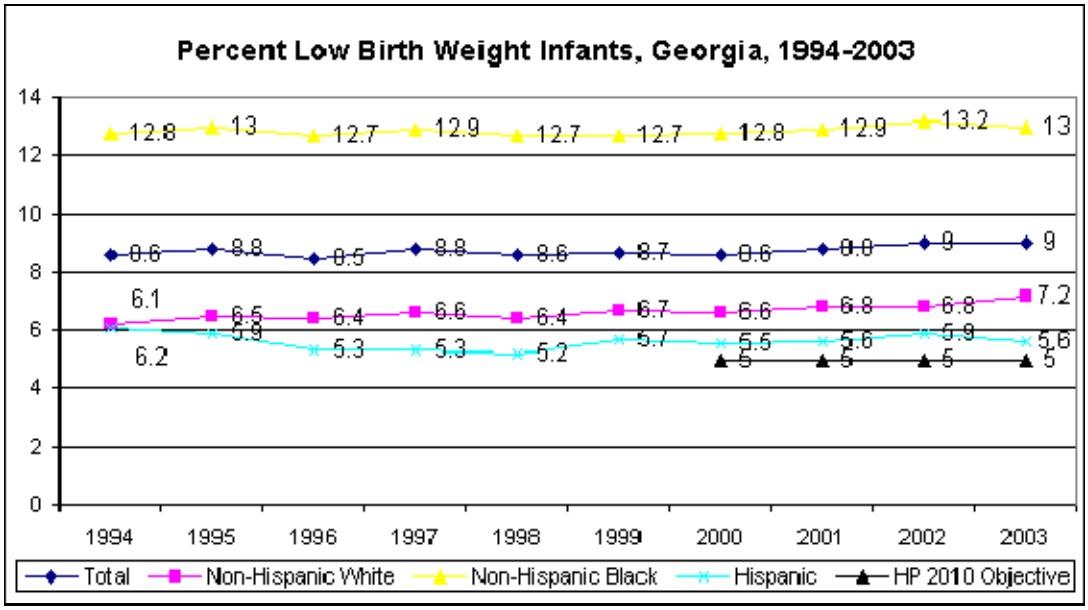
Data source: http://oasis.state.ga.us/webquery/mch.html

Although preterm births (births completed between 32 and 36 weeks of pregnancy) have increased during the ten-year period, very preterm births (births completed between 20 and 31 weeks of pregnancy) have decreased overall and for both races. Very preterm births decreased by 13%, from 2.3% to 2.1%, during the time period. Very preterm births among Blacks have decreased from 3.9 per 100,000 to 3.4 per 100,000 and remained at this level for the last five years of the time period.



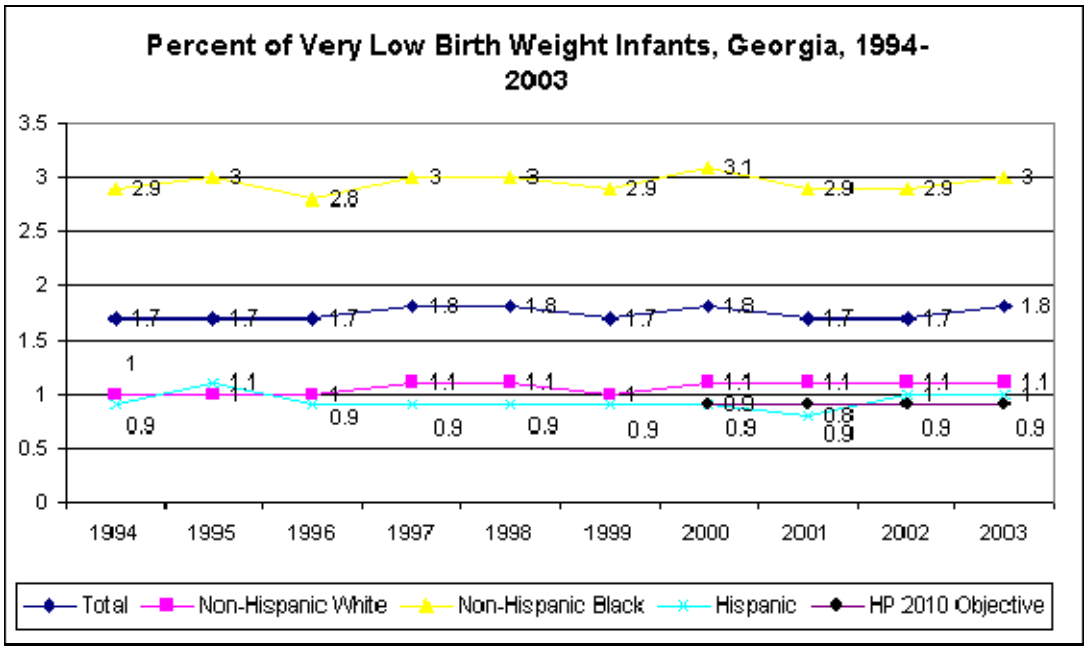
Data source: http://oasis.state.ga.us/webquery/mch.html

The **percent of low birth weight infants** (live births weighing between 1500 and 2499 grams) increased by 4.7%, from 8.6 % to 9%, between 1994 and 2003. While the percent of low birth weight non-Hispanic Black infants increased by 1.6% in this time period, the percent increase for non-Hispanic White infants was 18%.



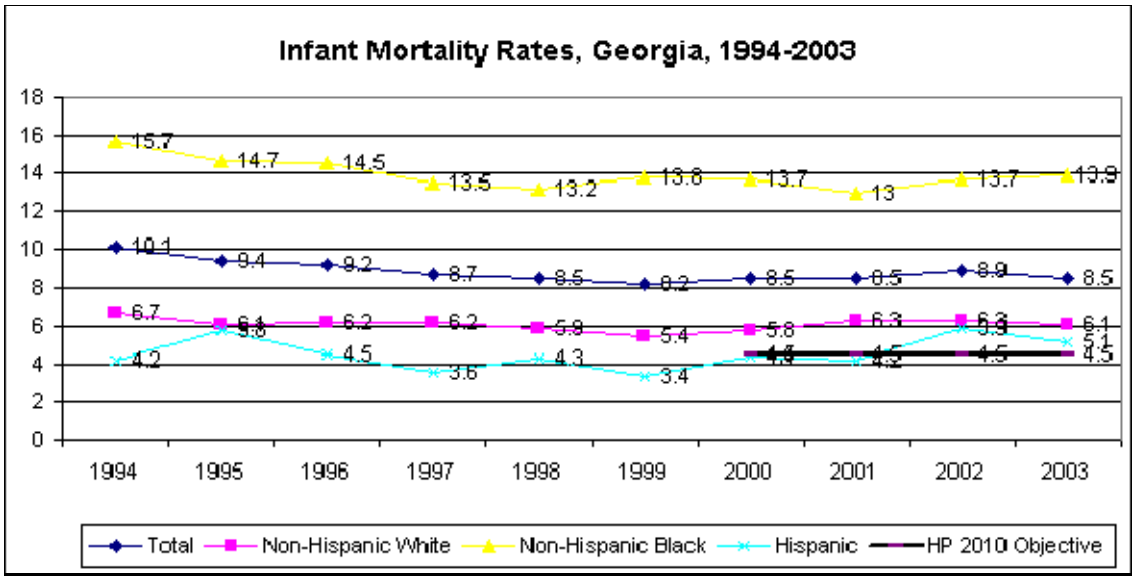
Data source: http://oasis.state.ga.us/webquery/mch.html

The **percent of very low birth weight infants** increased even more than the percent of low birth weight infants, rising 6% between 1994 and 2003. The percent of very low birth weight non-Hispanic White infants increased 10%, very low birth weight non-Hispanic Black infants increased 3.4%, and very low birth weight Hispanic infants increased 11.1%.



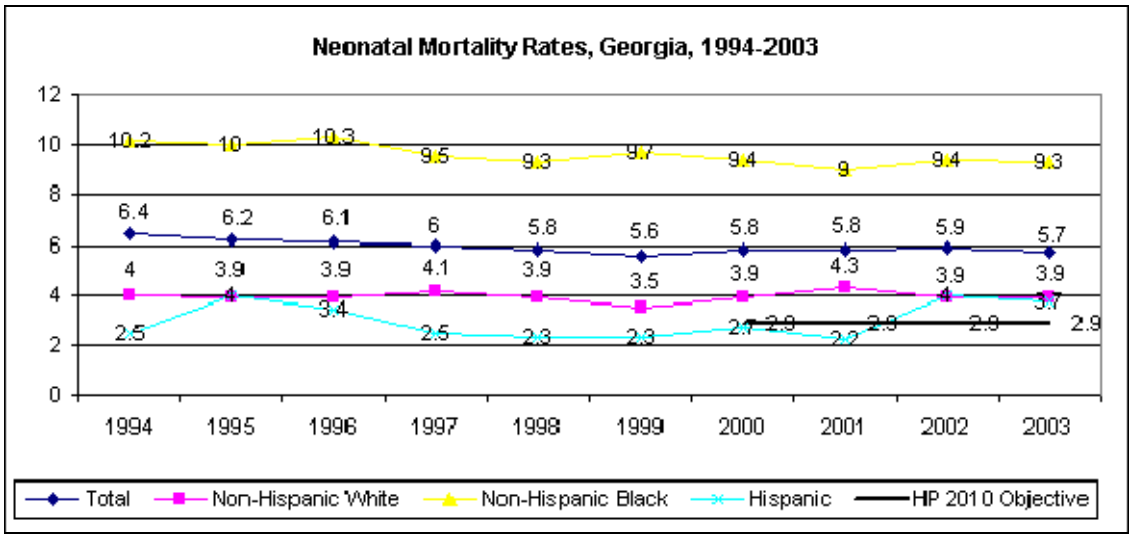
Data source: http://oasis.state.ga.us/webquery/mch.html

Infant Mortality: Between 1990 and 2003, Georgia moved from 47th to 43rd in the national rankings on the measure of **infant mortality**. Infant mortality among all race/ethnic groups decreased in the period between 1994 and 2003. Overall, infant mortality decreased 19% from 10.1 per 100,000 births to 8.5 per 100,000 births in this period. The infant mortality rate in 2003 was 8.5, compared to the U.S. rate of 6.9. However, among non-Hispanic Blacks, the decrease in this period from 15.7 per 100,000 to 13.9 per 100,000 places Georgia under the U.S. 2003 infant mortality rate of 14.1 per 100,000. In contrast, among non-Hispanic Whites, the infant mortality rate decreased 8.9% in this period to 6.1 per 100,000, but remains slightly higher than the U.S. rate of 5.8 for this group. To some extent, the fact that the Georgia rate is higher than the U.S. rate is driven by the increasing number of Hispanics births in the state and the 21.4% infant mortality increase in this population.



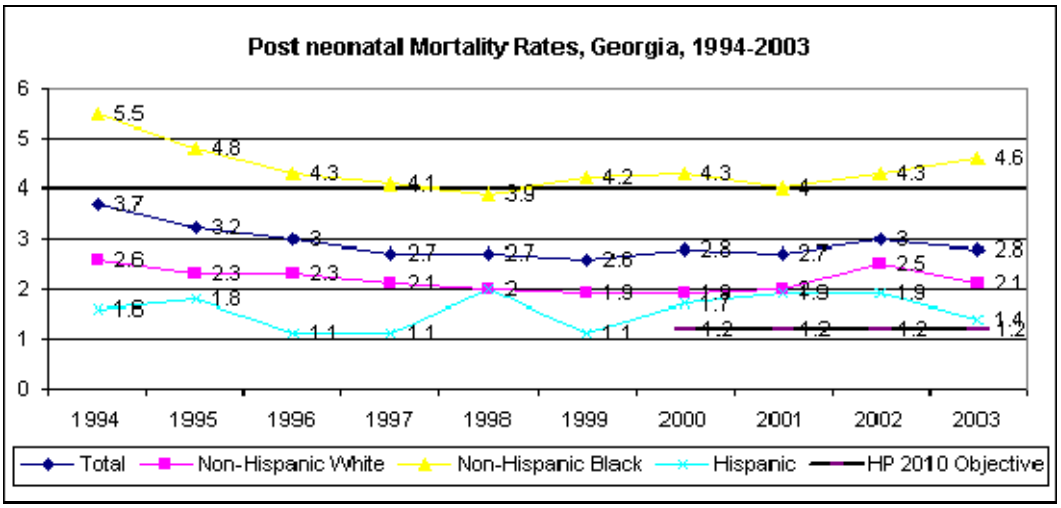
Data source: http://oasis.state.ga.us/webquery/infantdeath.html

The **neonatal mortality** rate decreased among both non-Hispanic Whites (2.5%) and Blacks (8.8%). The overall nenonatal mortality rate decreased 10.9% between 1994 and 2003. The neonatal mortality rate among non-Hispanic Whites is 3.9 per 100,000 and among Blacks is 9.3 per 100,000 as compared to the U.S. rate of 4.7 and Healthy People 2010 objective of 2.0.



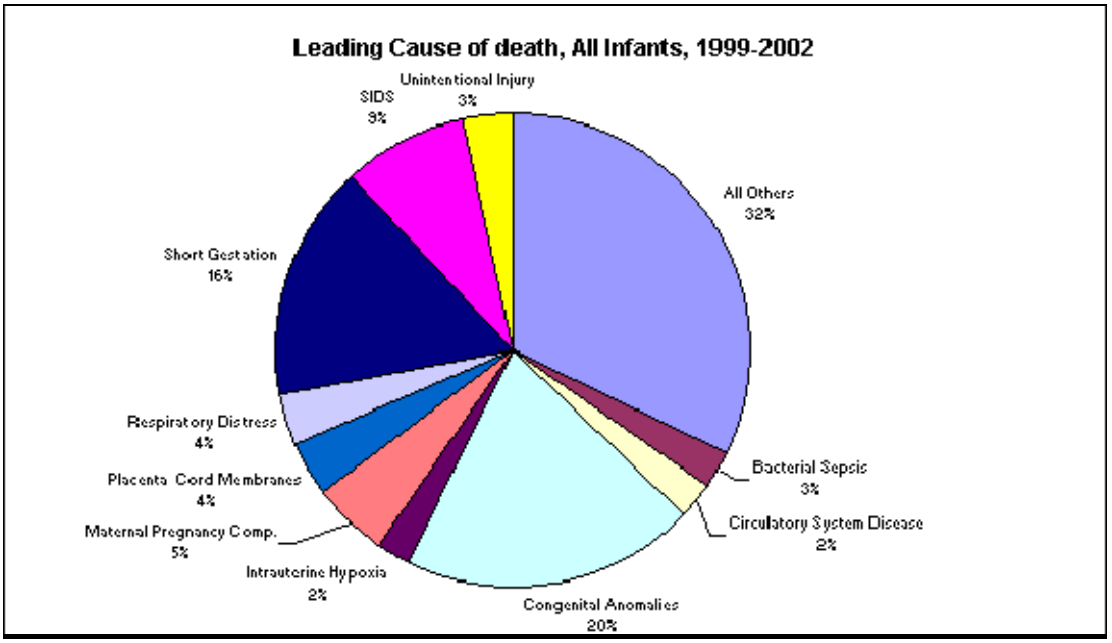
Data source: http://oasis.state.ga.us/webquery/infantdeath.html

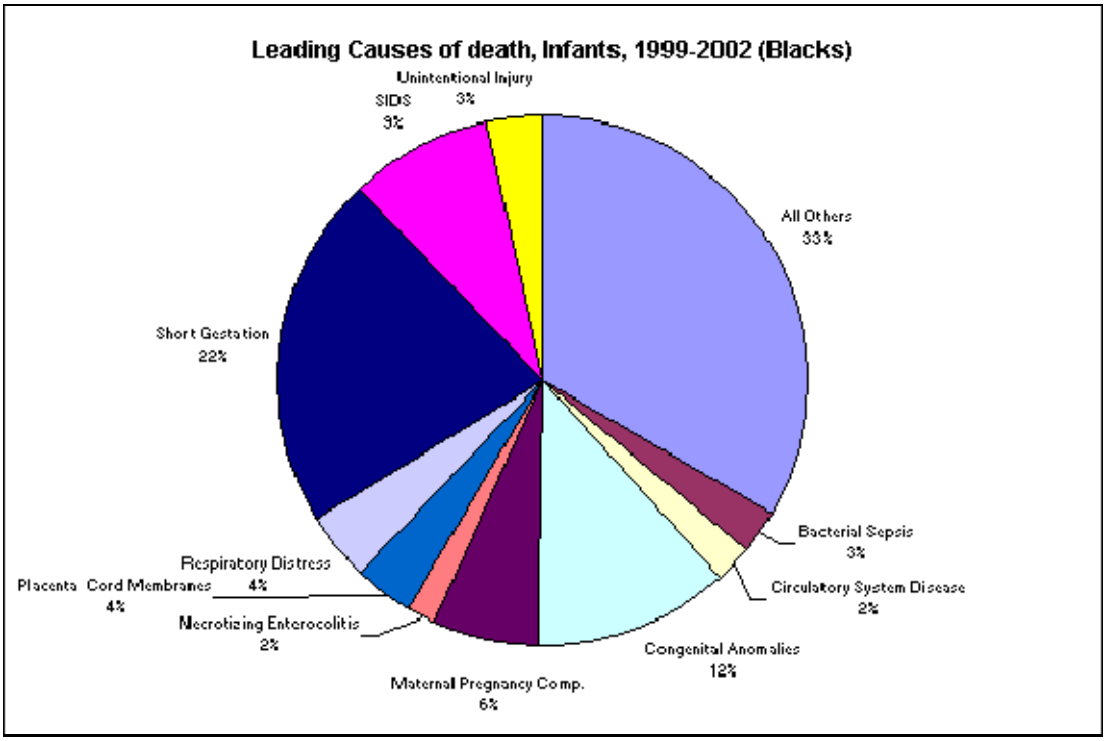
The **post neonatal mortality rate** decreased among both non-Hispanic Whites (19%) and Blacks (16.4%). The overall post nenonatal mortality rate decreased 24.0% between 1994 and 2003. The post neonatal mortality rate among non-Hispanic Whites is 2.1 per 100,000 and among Blacks is 4.6 per 100,000 as compared to the U.S. rate of 2.3 and Healthy People 2010 objective of 1.2.

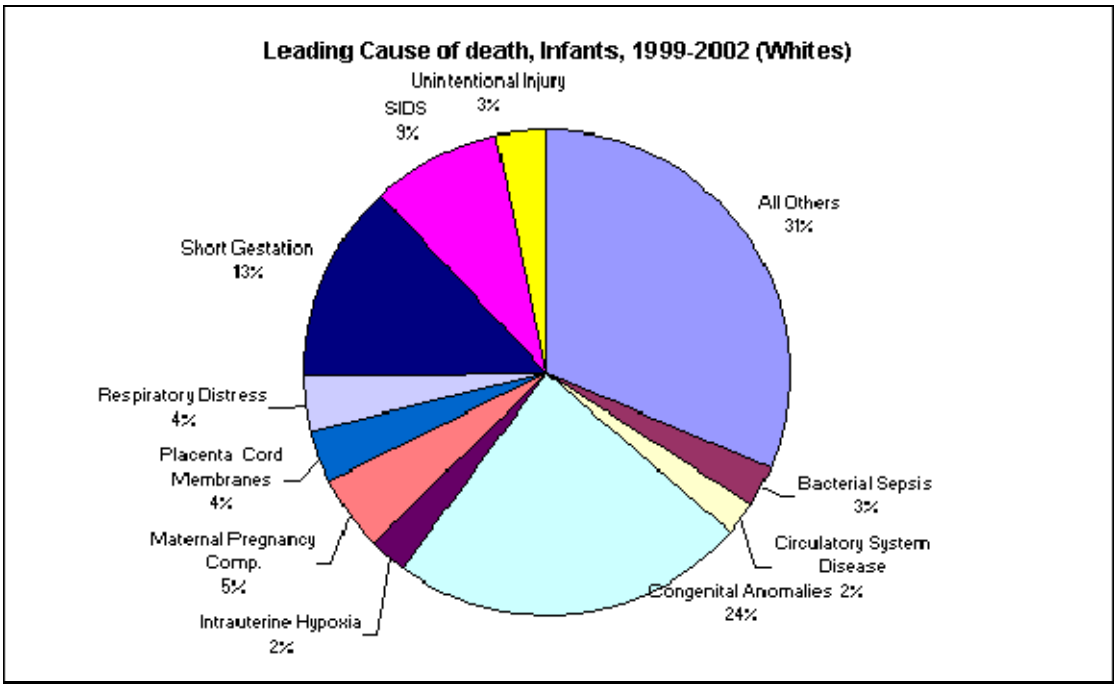


Data source: http://oasis.state.ga.us/webquery/infantdeath.html

Approximately two-thirds of Georgia **infant deaths** occur during the first 28 days after birth, or the neonatal period, and are due to health problems of the infant or pregnancy. Congenital anomalies (24%) represent the leading cause of death for White infants, while short gestation (22%) represents the leading cause of death among Black infants. Among White infants, short gestation (13%) is the second leading cause of death and conversely, congenital anomalies (12%) among Blacks. The third leading cause of death among both groups is SIDS (9%). SIDS is the leading cause of deaths for infants over one month of age.

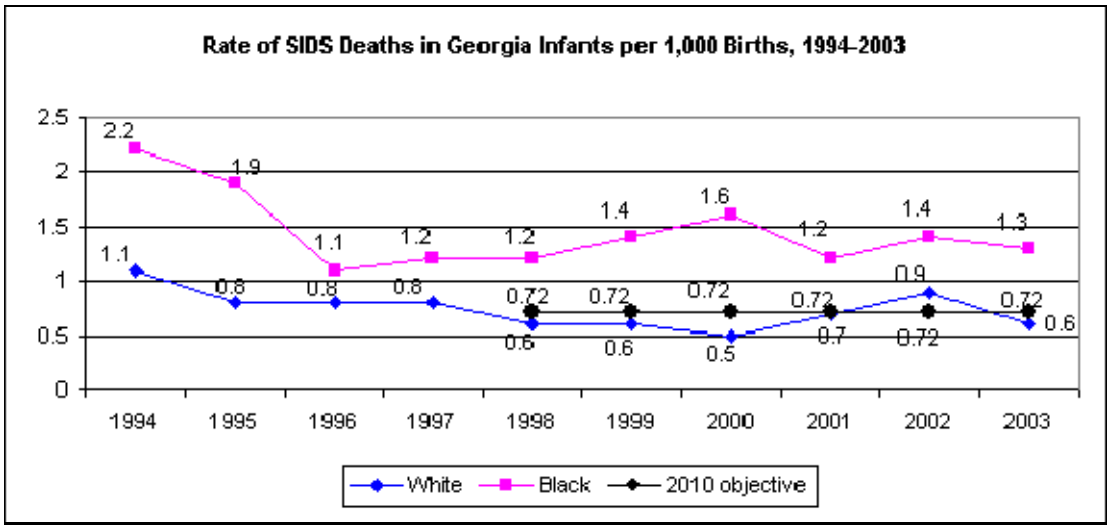






Data source: http://oasis.state.ga.us/webquery/infantdeath.html
Congenital anomalies: analysis of data from Georgia Birth Defects Reporting and Information System (MCH Epidemiology Section)

Significant decreases in **SIDS** have occurred during the ten-year time period 1994 to 2003. After a short drop early in this time period, the overall SIDS death rate for Black infants decreased from 2.2 per 100,000 to 1.3 per 100,000, a decrease of 40.9%. Among White infants, the SIDS rate decreased during this time period 45.5%, dropping from 1.1 per 100,000 to 0.6 per 100,000 in 2003. The Healthy People 2010 objective is 0.72 per 100,000.



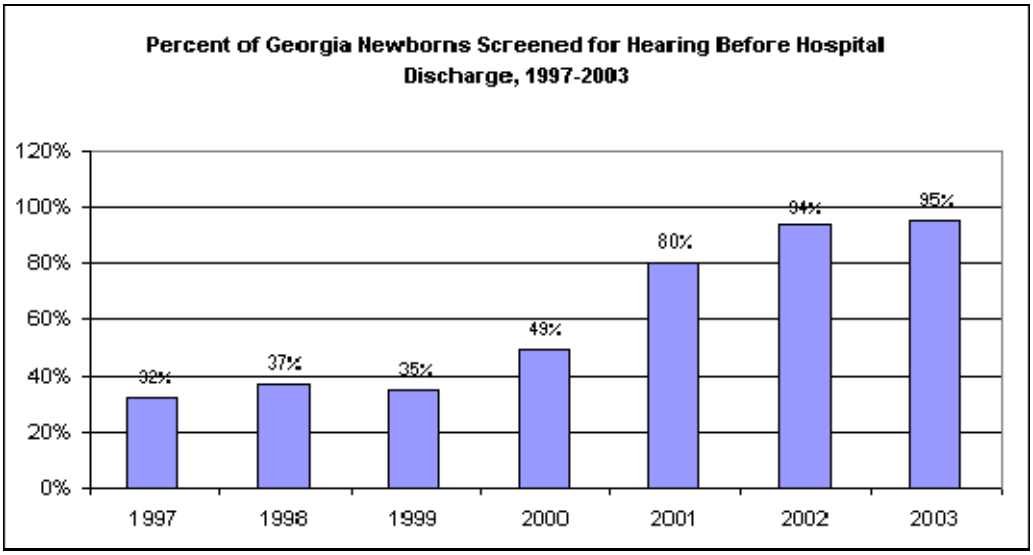
Data source: http://oasis.state.ga.us/webquery/infantdeath.html

Infant Morbidity:

The two leading congenital anomalies among Georgia infants are heart malformations and cleft lip or palate. The third most frequent congenital abnormality is Down Syndrome. Since 1967, the CDC Metropolitan Atlanta Congenital Defects Program (MACDP) has been conducting active surveillance in the core five county metro Atlanta area; 3.3% of all live births in this area involved a major birth defect.

The Georgia Public Health Laboratory performs screening for hemoglobinopathies, including sickle cell and metabolic conditions. The incidence rate for diagnosed cases of hemoglobinopathies is 1 per 1,300 births. The rates for various metabolic conditions range from 1 per 4,000 births for hypothyroidism to 1 per 400,000 births for tyrosinemia. Other conditions tested for include glactosemia (1 per 40,000 births), phenylketonuria (1 per 17,000 births), congenital adrenal hyperplasia (1 per 19,000 births), biotindidase deficiency (1 per 60,000 births), homocystinuria (1 per 300,000 births), and maple syrup urine disease (1 per 300,000 births).

With the institution of **Universal Newborn Hearing Screening and Intervention** in Georgia in 2000, the percentage of newborns screened for hearing prior to hospital discharge increased almost three-fold between 1997 and 2003, rising from 32% to 95%.



Data source: UNHS Program data (ICH Section/FHB)

Early and Middle Childhood Highlights

There are over 2,200,000 children in Georgia (2005 estimate). Well-being starting at birth and moving into middle childhood sets a child on the path to success as a self-sufficient adult contributing to his or her family and community. While significant strides have been made in the last decade, Georgia's children continue to be less healthy than their counterparts in most other states, and do not fare as well in educational achievement. Children in Georgia continue to be born into circumstances that place them at risk throughout their childhoods. The health care children receive from birth and the habits and attitudes that begin to develop in childhood carry over into adolescence and adulthood. A Healthy Start Index, developed by the Georgia Family Connection Partnership, shows no change in the period from 1998 to 2002, with the Index remaining stable at 73 out of 100.

Georgia ranks 40th among all states in the *2004 KIDS COUNT Data Book* that reports on the well-being of America's children, up from 47th in the U.S. ten years ago. Between 1996 and 2001, Georgia improved on seven out of ten measures that reflect child well-being. This improvement is reflected in metro Atlanta, which rose from last (25th), in 1990, in a national rank done by the Kid-Friendly Cities Health Improvement Report to first in the most recent report. This report includes a wider spectrum of measures than just health, looking at the context in which children live, including the economy and the environment.

Middle Childhood Study: In 2004, FHB began a review of health and well-being issues of children ages five through nine. (This age definition was selected because WIC programs end at the 5th birthday and Adolescent Health and Youth Development programs begin at the 10th birthday.) The study found that well-being in middle childhood, as defined as ages five through nine, sets a child on the path to success as a worker, a parent, and a citizen. During middle childhood, children begin school, grow in size, and develop their outlooks on life. Healthy children are more likely to attend school regularly, navigate the teenage years successfully, and become self-sufficient, productive adults. Relative to other children, children between the ages of six and 11 have received little attention from health researchers and policymakers. There are substantial health issues in middle childhood that merit close attention. Middle childhood is an important link in the continuum between early childhood and adolescence.

An overview of Georgia's children ages five through nine found the following major health issues:

- The most prevalent medical causes of school absenteeism are asthma and oral health/dental health problems. The most common reasons for hospitalizations are asthma and falls. Death is caused most by motor vehicle crashes and drowning in open water (more frequently than in swimming pools). Other significant health concerns are overweight and obesity, mental health, emotional well-being, and childhood victimization, bullying, and the quality of mental health services. An important child abuse and neglect issue is "inadequate supervision."
- Access to health care, including medical homes, health insurance, and coordinated school based health programming are key systems issues.

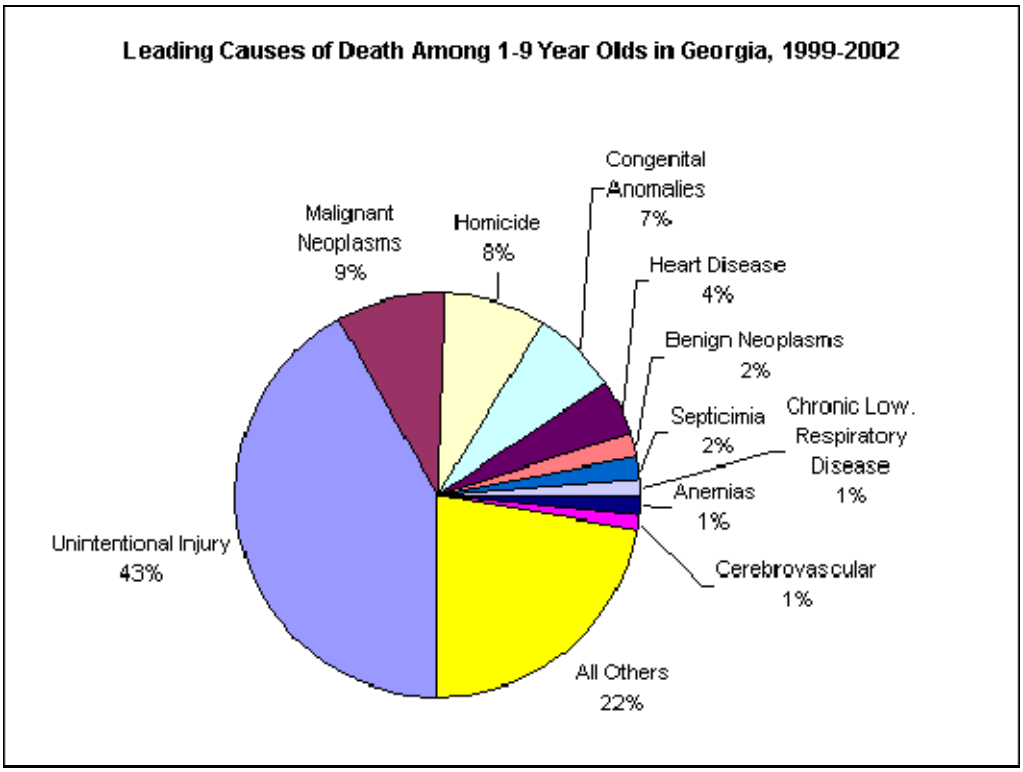
- Prevention needs are significant during middle childhood. Georgia places the focus on developmental assets as understood by The Search Institute, rather than taking a deficit approach. The state encourages motor vehicle safety, injury prevention, physical activity, and good nutrition for obesity prevention, and mental, emotional, and social well-being, including media literacy and safety, and water safety.

On October 19, 2005, FHB will convene knowledgeable people to discuss the demographics of children in middle childhood and review significant health issues and systems issues that may impact health and well-being. Short and long term plans will be developed related to various health and systems concerns, based on strong collaboration among stakeholders of the various health and systems concerns, that will be carried out in 2006 and beyond.

Georgia's 2005 MCH Needs Assessment early and middle childhood mortality, morbidity, and health care indicator highlights are provided in the section that follows.

Child Mortality: Unintentional injury accounted for 43% of all deaths to children ages 1 to 9 between 1999 and 2002. The leading cause of unintentional injury death was motor vehicle crashes. In 2002, 53 children ages 1-9 died in motor vehicle crashes; a disproportionate number of them were unrestrained or not properly restrained. Drowning is the second leading cause of injury related deaths of children. In contrast to younger children, children ages 4-13 are fourteen times more likely to die in a swimming pool than a motor vehicle. In 2002, 30 Georgia children drowned. The second and third leading causes of death were malignant and benign neoplasms (11%) and homicide (8%).

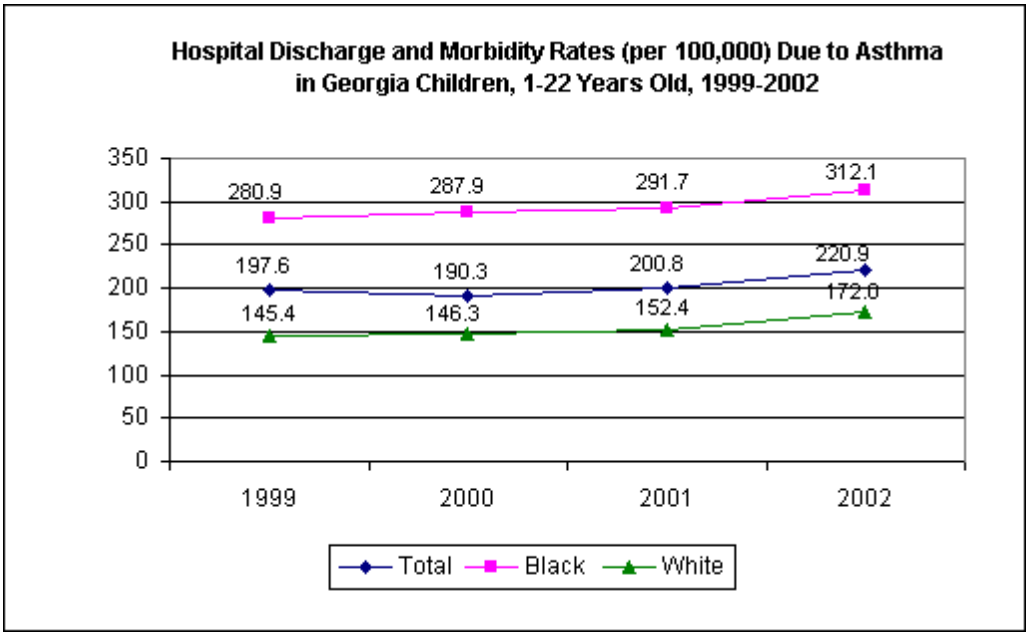
The *2004 KIDS* COUNT Report ranks Georgia 39th in the U.S. in the child death rate for children ages 1-14. Looking at Georgia Vital Records data, 337 children ages 1 through 12 died in 2003; 127 (37.7%) of these deaths were accidental in cause. According to the Georgia Child Fatality Review Panel, almost 40% of Georgia child deaths were definitely preventable and another almost 40% were possibly preventable. In 2002, 63 child deaths (ages 1-17) resulted from confirmed abuse/neglect and 47 deaths resulted from suspected abuse/neglect. In over two-thirds of child abuse/neglect related deaths, the child and/or family had prior involvement with at least one state or local agency. The county-level Child Fatality Review Committees determined that 77% of identified child deaths were definitely or possibly preventable.



Data source: http://webappa.cdc.gov/sasweb/ncipc/eadcaus.html WISQARS Leading Causes of Death Reports, 1999-2002

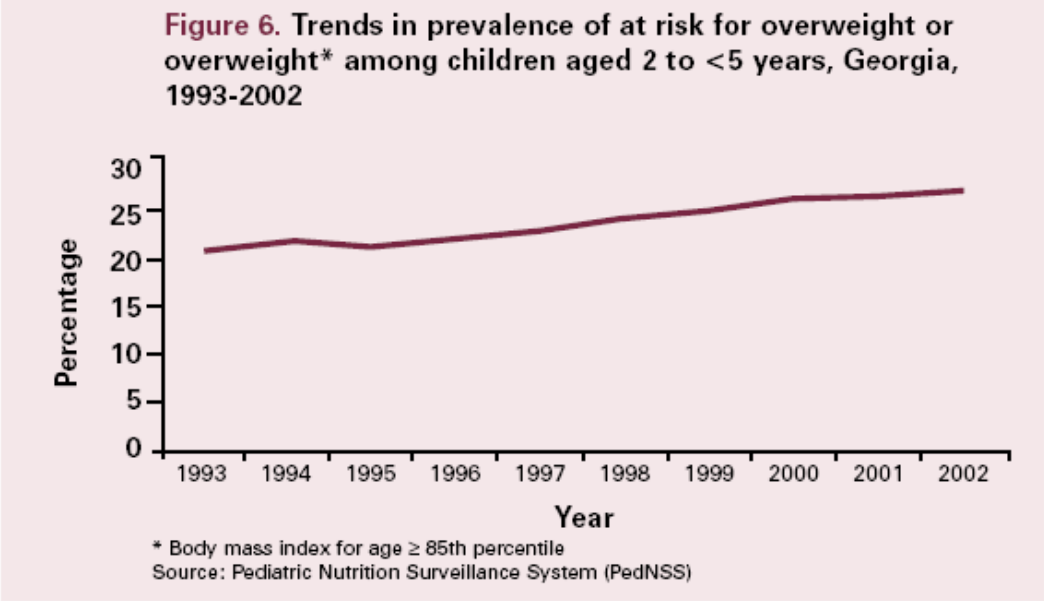
Child Morbidity: The rate of hospital discharges due to asthma increased by 11.8% overall from 1999 to 2002. About 12,000 Georgia children, or 6% of all those with asthma, reported being hospitalized overnight within the last 12 months. The hospital discharge for White children increased by 18.3% while the rate for Black children increased by 11.1%. Asthma is the leading cause of hospitalizations among Georgia's children. Among children ages 5-9, falls and unintended injuries are second to asthma as causes of hospitalization.

In Georgia, 10% of children ages birth to 17 have asthma and approximately 9% of Georgia children under the age of five have asthma. About one in six Georgia households (15.7%) include a child with asthma. Asthma rates among children vary significantly by race/ethnicity and sex. More than half of the children with asthma have had an attack in the last 12 months and almost one-third have had an emergency room visit during the same time period, an estimated 64,000 children.



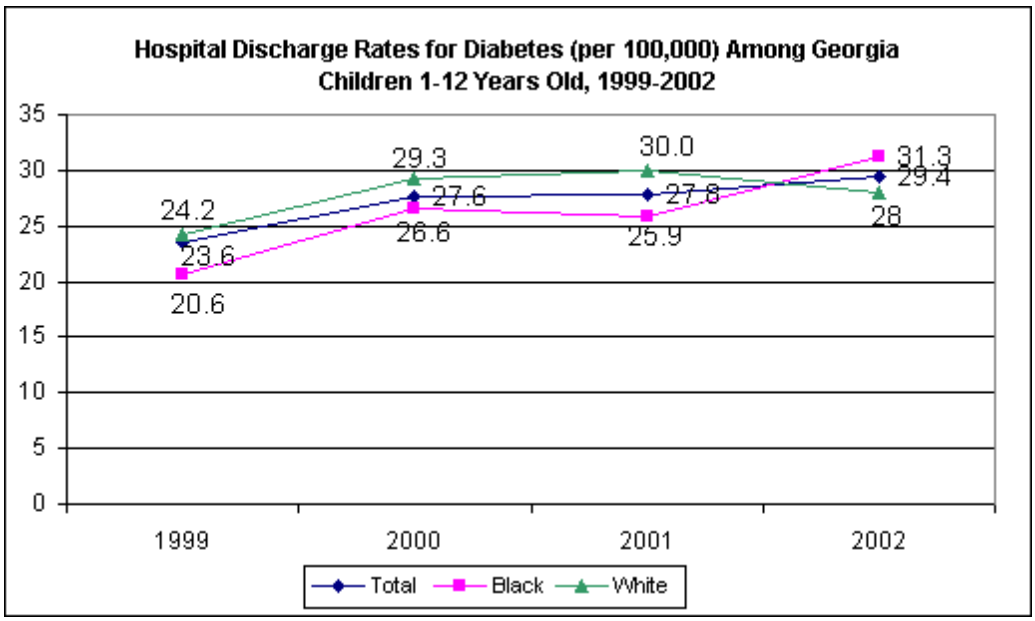
Data source: http://oasis.state.ga.us/webquery/death.html

A steady increase in the prevalence of **risk for overweight or overweight among young children** participating in WIC has been seen, rising from 21% in 1993 to 26% in 2003. Over one-fourth of children, ages 2-5, participating in the Georgia WIC Program were at risk for overweight (14%) or overweight (12%). Among Hispanic participants in the WIC Program, over one-third (35%) were at risk for overweight or overweight.



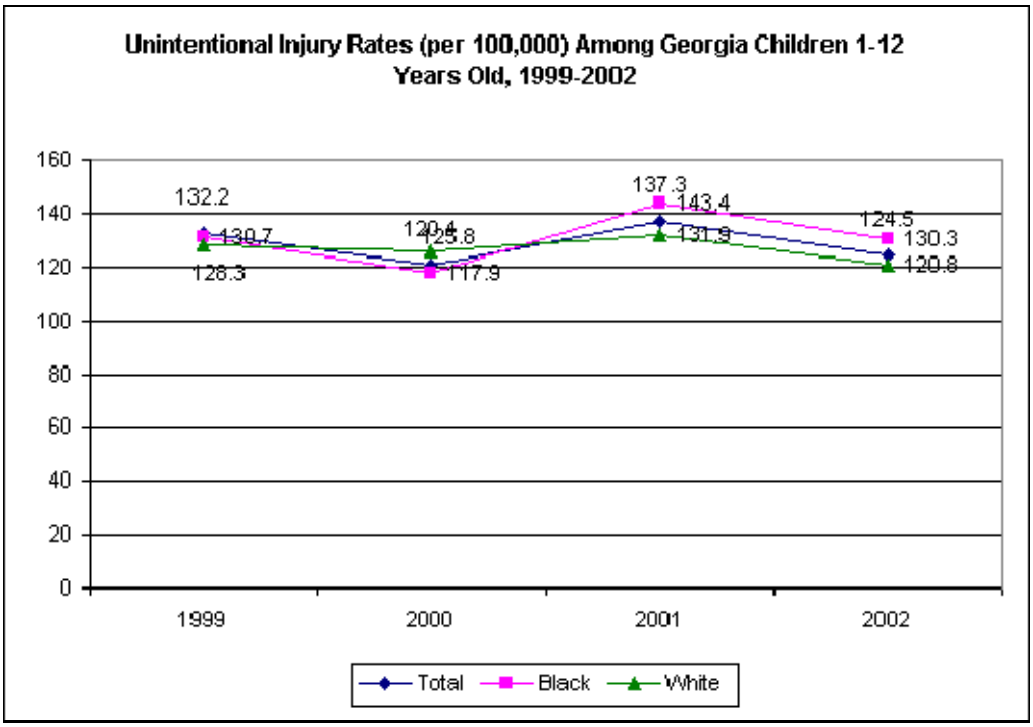
Date source: *Maternal and Child Health in Georgia Birth Through Age 5, 2004*, Georgia Division of Public Health

The rate of hospital discharges due to diabetes increased by 24.6% overall from 1999 to 2002. The hospital discharge for White children increased by 15.7% while the rate for Black children increased by 51.91% from 20.6 per 100,000 to 31.3 per 100,000.



Data source: http://oasis.state.ga.us/webquery/death.html (hospital discharge data)

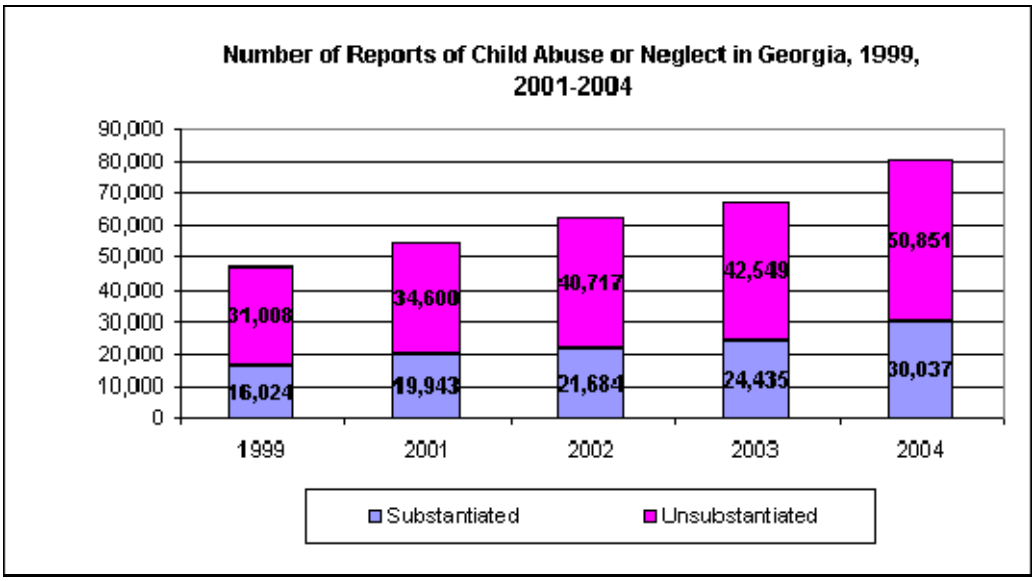
In Georgia, for every child injury death, there are about eight inpatient hospitalizations and an estimated 35 outpatient hospitalizations, about 270 emergency department visits, and 600 injury visits to physician offices. Between 1999 and 2002, the **rate of unintentional injuries** among Georgia children decreased by 5.8%; the same rate of decrease that occurred among White children. The decrease among Black children was only 0.3%.



Data source: http://oasis.state.ga.us/webquery/death.html

A significant increase in substantiated reports of **child abuse and neglect** occurred from 1999 to 2004. The number of cases rose from 16,024 to 30,037, an 87.5% rise.

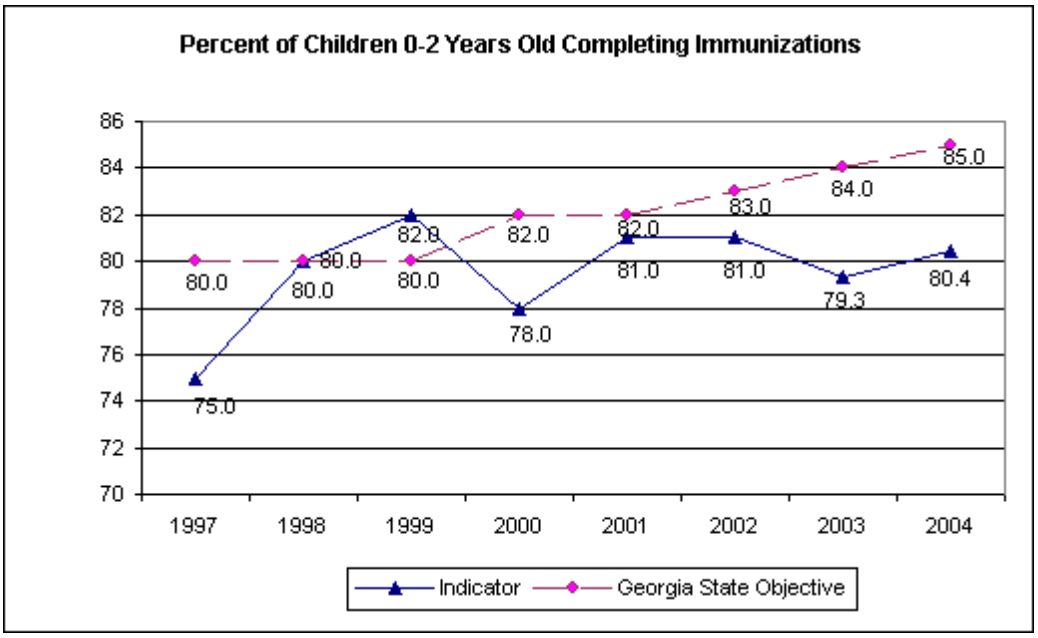
In June 2003, there were 55,197 children ages 5-9 in foster care. Neglect, parental drug abuse, physical abuse, inadequate housing, and parental inability to cope were the most frequently occurring reasons for removal from the home. According to DFCS, 25% of these foster care children have at least three chronic medical conditions; 35 to 50% have significant emotional and behavioral health problems; and more than half have developmental disabilities or delays.



Data source: Division of Family and Children Services – Key Performance Indicators, October 2004

Health Care Indicators: Georgia is one of 11 states in the country to have at least 80% of its two-years olds up to date on their **immunizations**, reaching the national coverage goal. Between 1997 and 2004, the percentage of children under age two who were completely immunized rose from 75% to 80.4%, an increase of 7.2%. In 2003, Georgia had no reported cases of tetanus or diphtheria and just 36 cases of pertussis. Three-quarters of all immunizations are administered in the private sector, while county health departments immunized 16% of Georgia's children. The percentage immunized in the private sector has increased significantly over the past five years. There is considerable variation from health district to health district in the proportion of two years old reported to be fully immunized, ranging from 59% in DeKalb to 92% in the Gainesville District. Only minor variation in immunization status of children occurs by the race and age of their mothers and by whether or not their mothers were Medicaid recipients.

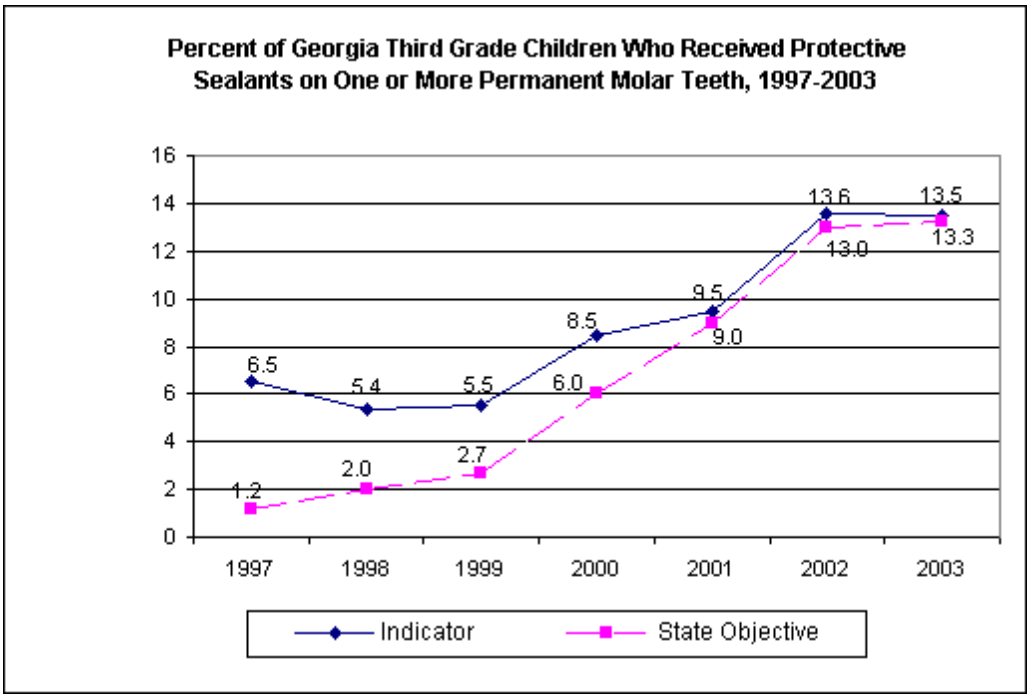
Several new vaccines have been introduced in the past ten years. Immunization against varicella, one of the newly introduced vaccines, showed the greatest coverage increase between 2000 and 2002, increasing by one-third to reach 89% of children. With the introduction of Prevnar vaccine in 2000, meningitis and some pneumonias and earaches in young children have been significantly decreased. In the metro Atlanta area, the rate of pneumococcal disease dropped by two-thirds between 1998-1999 and 2001.



*Immunizations for Measles, Mumps, Rubella, Polio, Tetanus, Pertussis, H.Influenza and Hepatitis B

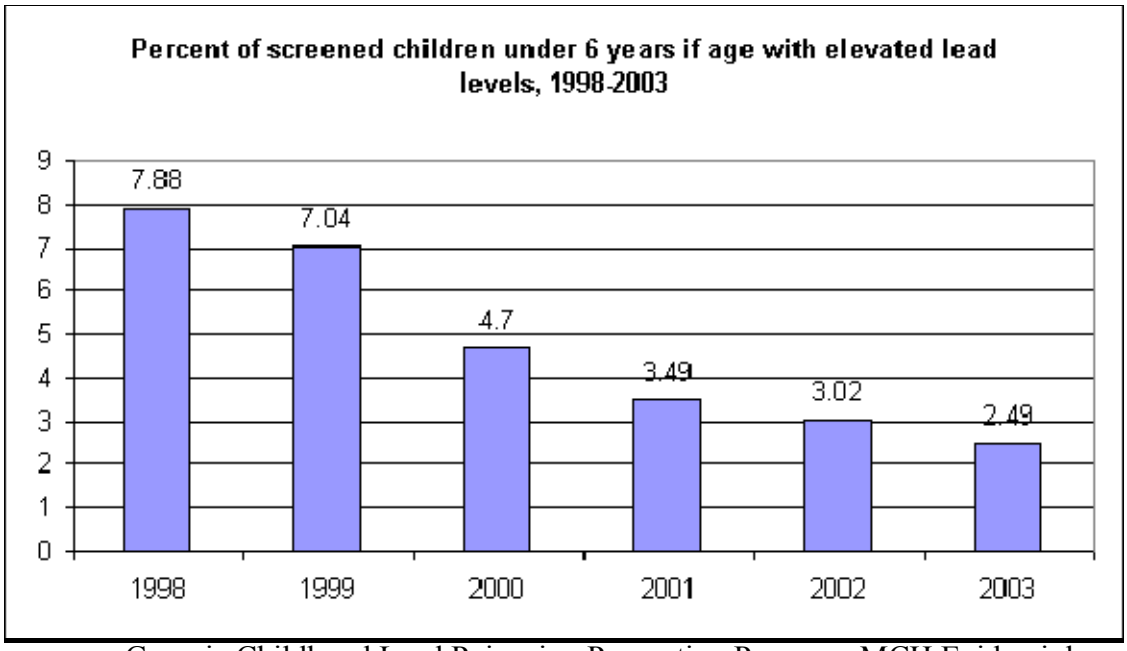
Date source: Georgia Immunization Survey, MCH Epidemiology

Between 1997 and 2003, the percentage of third grade children served by public health who received **dental sealants** more than doubled, increasing from 6.5% to 13.5%. In Georgia, in 2003, over 42,000 children ages birth to 19 visited fixed public health dental clinics. Over 61,000 public health clinic and prevention service visits were provided to children ages birth to 19. Dental sealants and fluoride mouth rinses were provided for over 29,000 children. More than 45,000 dental screenings were provided, with about 9% needing emergency treatment. A statewide third grade oral health screening survey including measurements of nutrition status has just been completed. The majority of the 3rd graders screened were between eight and nine years of age. Fifty-seven (57) percent of the children screened had experienced dental caries compared to the Healthy People 2010 objective of 42%; 27% had untreated caries (Healthy People objective 2010 of 21%), and 39% had dental sealants (Healthy People objective 2010 of 50%). Reports are being developed that will provide data on overall oral health and nutrition status of Georgia's third grade population.



Data source: FHB MCH Block Grant data from previous years

Lead is the number one environmental hazard for young children. The percentage of children in Georgia six years of age who were screened for lead and were found to have elevated levels steadily decreased between 1998 and 2003, a 68% drop.



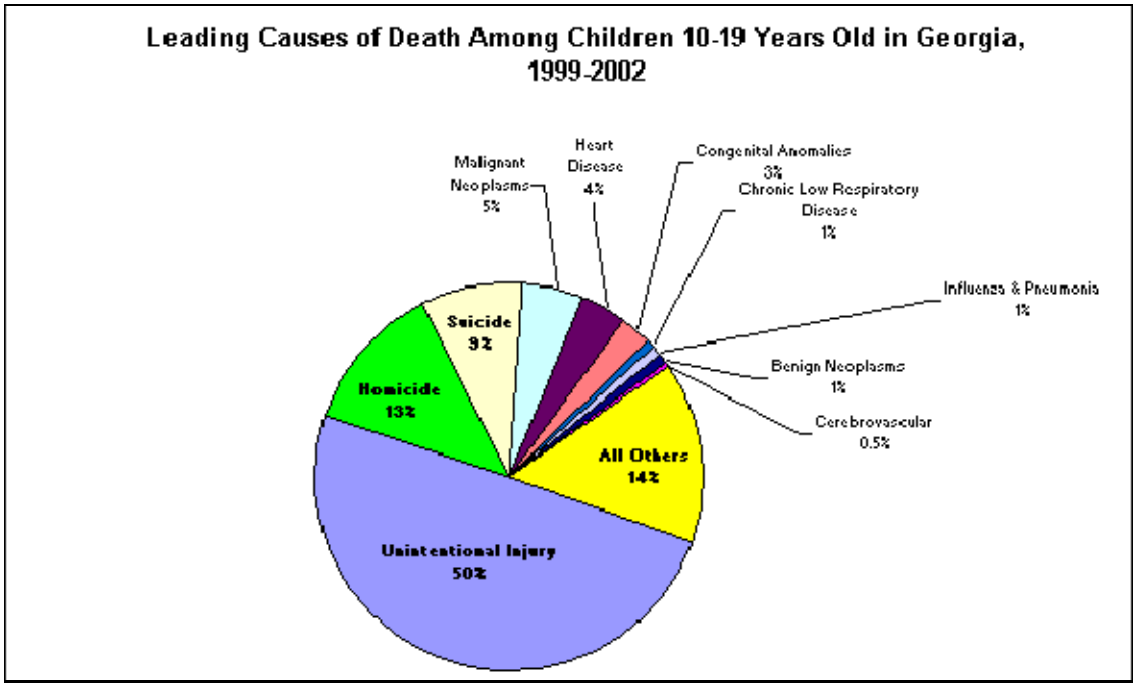
Data source: Georgia Childhood Lead Poisoning Prevention Program, MCH Epidemiology

Adolescent Highlights

Some risk behaviors developed and/or initiated in adolescence pose immediate health threats while others have a documented relationship to long-term health concerns and/or put teens at greater risk for disease and death in adulthood. Furthermore, there is overwhelming evidence of connections among an adolescent's involvement in the risk behaviors of drugs, alcohol, tobacco, sex, and violence. In Georgia, we also acknowledge that adolescents' health are influenced, not only by the strengths a vulnerabilities of individuals adolescents, but also by the character of the settings in which they lead their lives.

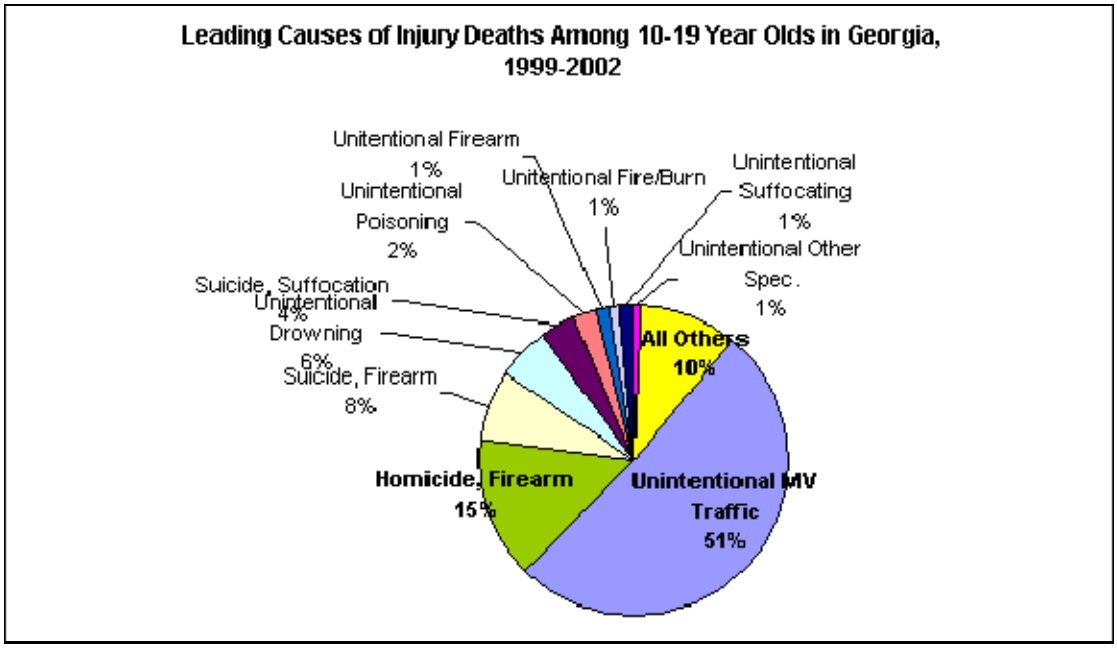
Adolescents also engage in positive behaviors that reduce both immediate and long-term health risk. These include avoidance of tobacco and other drugs, physical activity, good dietary habits, safe use of seatbelts and other injury prevention devices, and positive reproductive health behaviors. In the decade from 1993 to 2003, there have been many positive trends in the areas of teen pregnancy, personal safety, violence, and suicide among youth. However, we cannot lose sight of other data on adolescents in Georgia, which show discouraging trends related to nutrition, physical activity, and drug use.

Adolescent Mortality: Georgia ranked 36th in 2001 in the U.S. in the rate of teen deaths by accident, homicide, or suicide among 15-19 year olds. In 2003, 522 youth ages 13-19 died in Georgia, with 272 dying as a result of accidents. The leading causes of death among Georgia 10-19 year olds (1999-2002) were unintentional injury (50%), homicide (13%), and suicide (9%).



Data source: http://webappa.cdc.gov/sasweb/ncipc/leadcaus.html WISQARS Leading Causes of Death Reports, 1999-2002

Of the leading causes of death, unintentional motor vehicle/traffic deaths accounted for 51% of all injury deaths, followed by homicide by firearm (15%). Despite this discouraging trend, among 32 states participating in the YRBS, Georgia ranks 5th best in the percentage of high school students reporting they rarely or never wore seatbelts, 9.4% compared to 15.1% nationally. Further, from 1990 to 1997, the number of 16 and 17 year olds killed in car wrecks declined by 29%. One year prior to this decline, Georgia had established a teen driving curfew, restricted the number of teen passengers in a vehicle, and implemented a statewide awareness campaign.

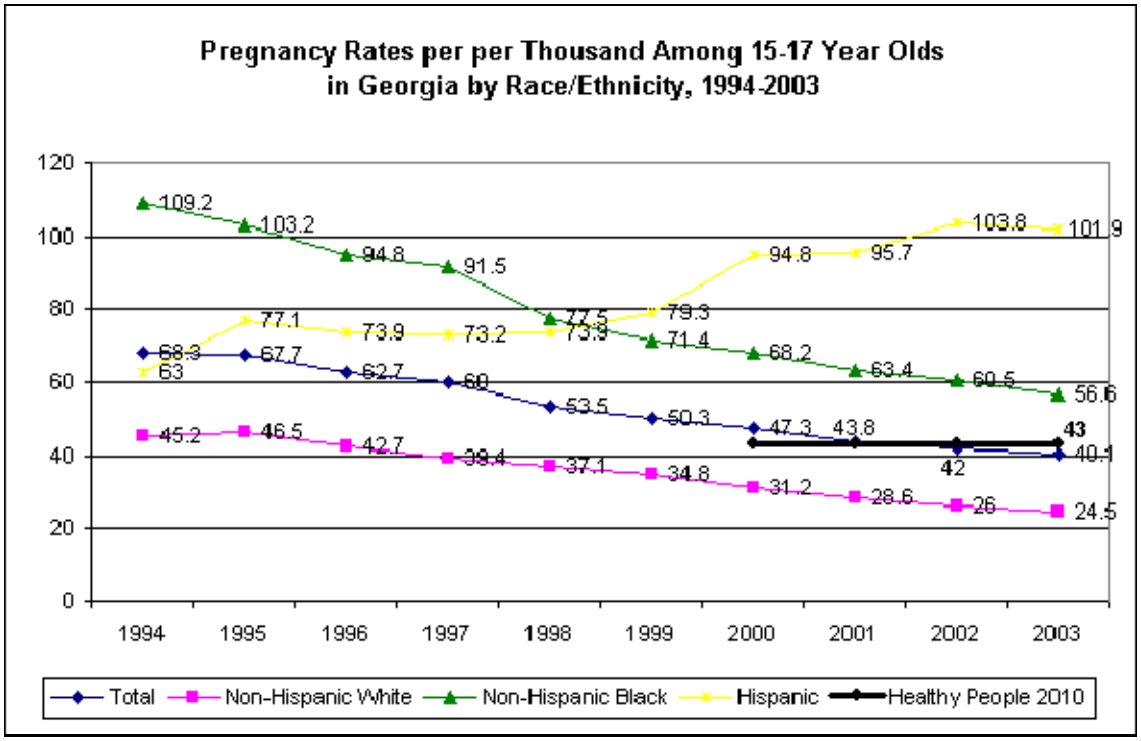


Data source: http://webappa.cdc.gov/sasweb/ncipc/leadcaus.html WISQARS Leading Causes of Death Reports, 1999-2002

Reproductive Health: Nationally, fewer than one-third of teen mothers ever finish high school, making them far more likely to raise their children in poverty. More than half of all women on TANF had their first child as a teen. The children of teen mothers are more likely to live in a single parent home. Teens who are unmarried at age 19 are 59% more likely not to have married by age 35. Teen mothers are more likely to give birth to premature or low birthweight babies, which is associated with developmental disabilities that later can interfere with school success. The children of teen mothers are 50% more likely to repeat a grade in school. Among the children of teen mothers, girls are 22% more likely to become teen mothers themselves and boys are three times more likely to become incarcerated.

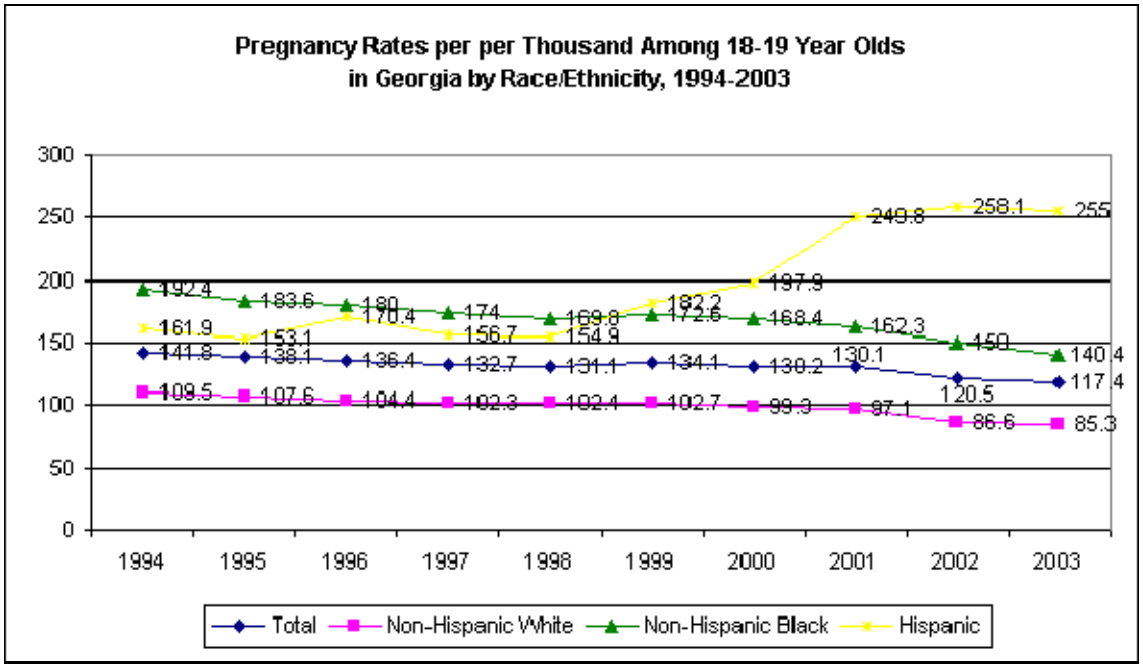
Teen births are of major concern in Georgia. In the *2004 KIDS COUNT Data Book*, Georgia ranked 45th in the nation in teen births.

Teen Pregnancy Rates: Georgia ranked 43rd highest among all states in teen births, with 16,581 babies born to girls aged 10-19 in 2002. However, Georgia's teen pregnancy rates for 15-17 year olds have dramatically improved between 1994 and 2003, with the 2003 rate of 40.1 being lower than the national Healthy People 2010 objective of 43 pregnancies per 100,000. The overall decrease during this period was 43%, with a decrease of 48.7% among non-Hispanic Blacks and a decrease of 45.8% among non-Hispanic Whites; however, the pregnancy rates for Hispanic teens increased by 61.7%, from 63 pregnancies per 100,000 to 101.9. Although the Hispanic teen rate rose in Georgia, it fell 20% nationally in the same time period. While Georgia Hispanic girls comprise 5% of the female population ages 15-19, they represent 15% of all births in this age group.



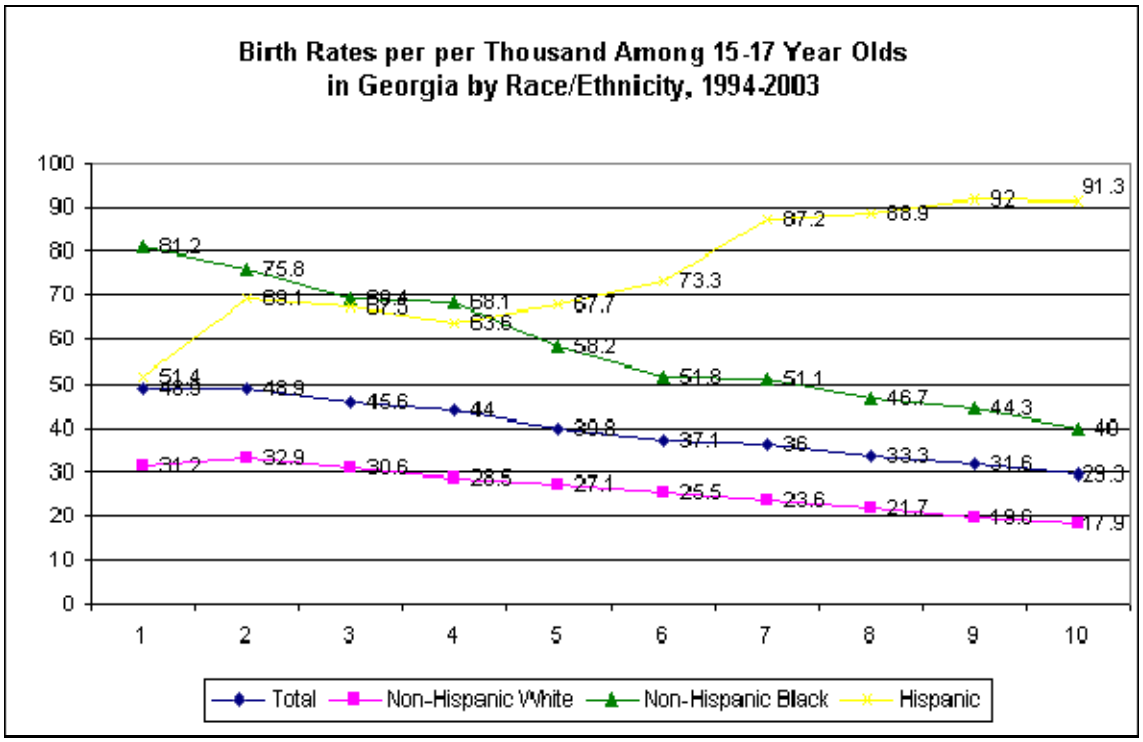
Data source: http://oasis.state.ga.us/webquery/mch.html

Among slightly older teens (ages 18-19) in Georgia, the overall pregnancy rate decreased by 17.2% from 1994 – 2003. During this same time period, the pregnancy rate among non-Hispanic Blacks decreased by 27% and by 22% for non-Hispanic Whites. Paralleling trends shown among younger teens in Georgia, during the period 1994-2003, the pregnancy rate also increased significantly among Hispanic teens, ages 18-19 (57.5%).



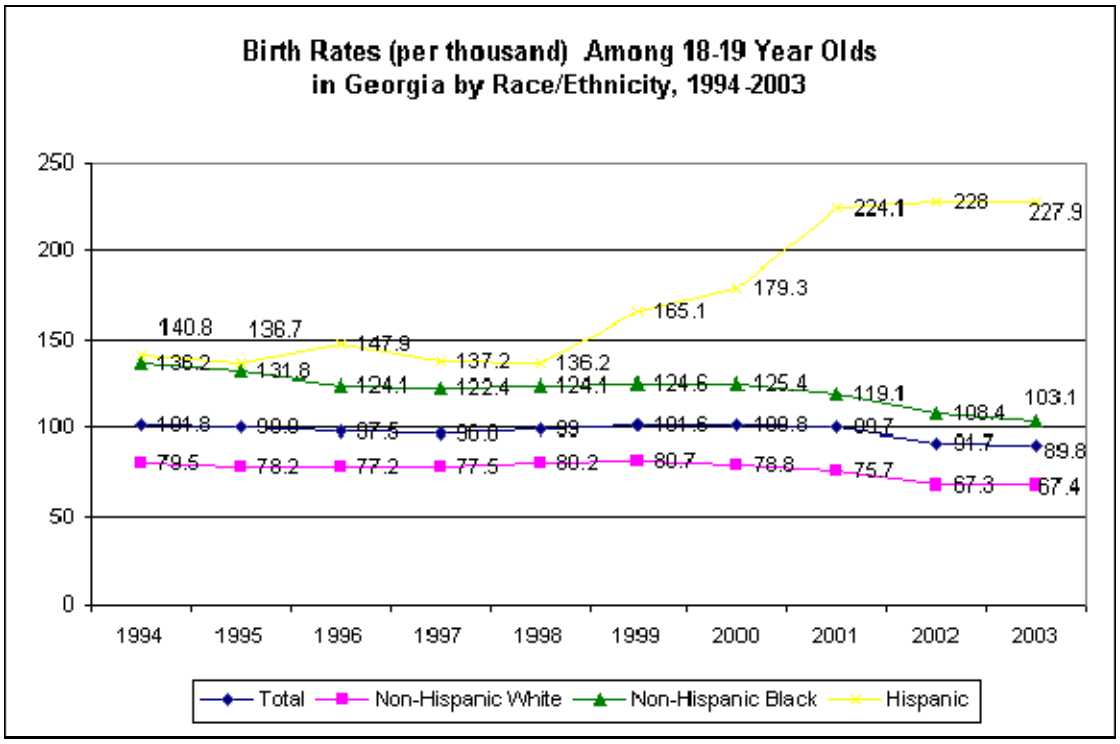
Data source: http://oasis.state.ga.us/webquery/mch.html

The **overall rate of birth among 15-17 year olds** in Georgia decreased by 19.8% between 1994 and 2003 to 29.3 per 1,000 compared to the U.S. birth rate of 22.4 per 1,000. The rate of birth among non-Hispanic Blacks decreased more sharply, by 50.7% from 81.2 per 1,000 in 1994 to 44.0 in 2003. During this same time period, the birth rate among non-Hispanic Whites decreased by 42.6% to 17.9 per 1,000, a rate lower than the U.S. rate of 19.8 per 1,000.



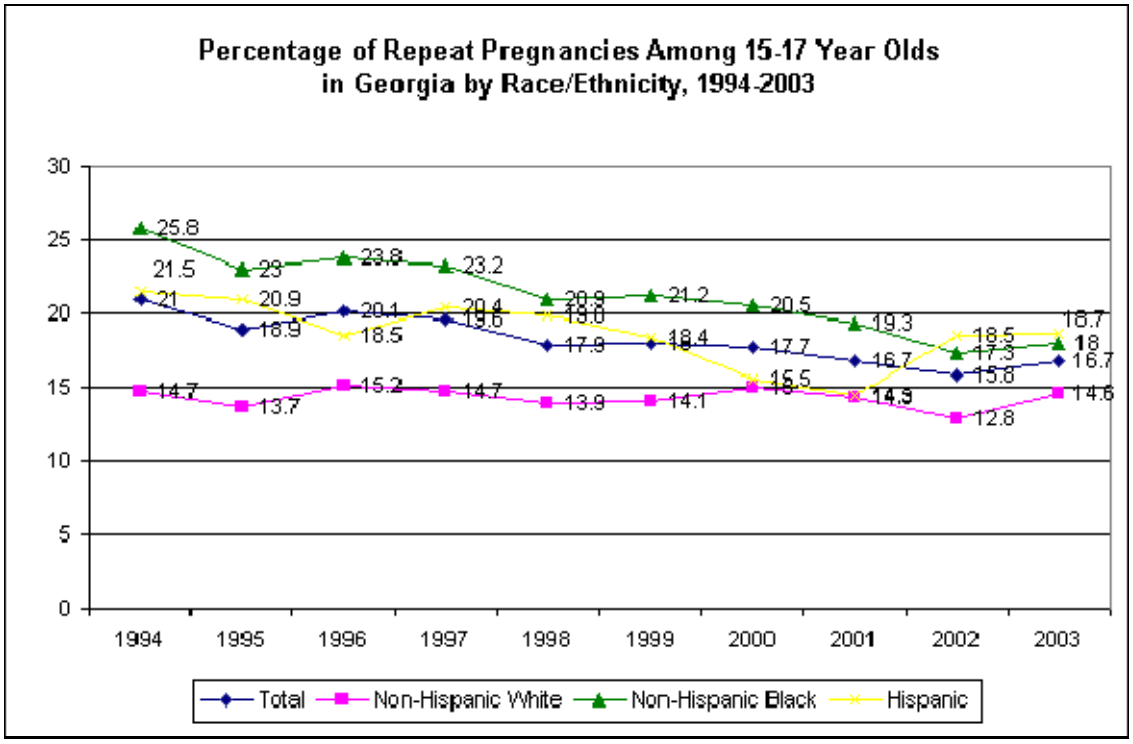
Data source: http://oasis.state.ga.us/webquery/mch.html

The overall **rate of birth among 18-19 year olds** in Georgia decreased by 11.8% between 1994 and 2003 to 89.8 per 1,000, compared to the U.S. birth rate of 70.8 per 1,000. The rate of birth among non-Hispanic Blacks decreased more sharply, by 75.7% and is now slightly lower (103.1 per 1,000) than the U.S. rate (106 per 1,000). During this same time period, the birth rate among non-Hispanic Whites decreased by 15.2% to 67.49 per 1,000, and is similar to the U.S. rate of 66.3 per 1,000. However, the Hispanic teen birth rate, increased by 61.8%, rising to 227.9 per 1,000 in 2003. This indicates that one out of every four Hispanic female teens ages 18-19 gave birth in 2003.



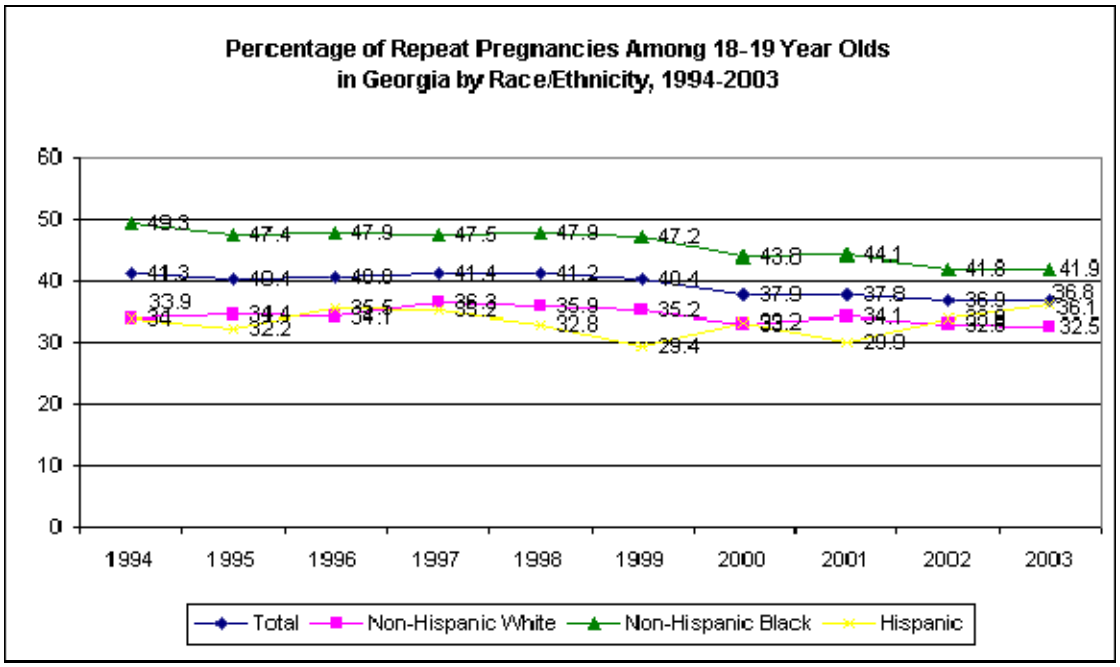
Data source: http://oasis.state.ga.us/webquery/mch.html

Paralleling overall state adolescent pregnancy trends, the rates of Georgia teens 15-17 having **repeat pregnancies** have also declined. The rate of repeat pregnancy for all race/ethnic groups declined between 1994 and 2003, with an overall decrease of 19.8% and a decrease among non-Hispanic Blacks of 31%. The rate of repeat pregnancy among young Hispanic teens decreased by 16.3%.



Data source: http://oasis.state.ga.us/webquery/mch.html

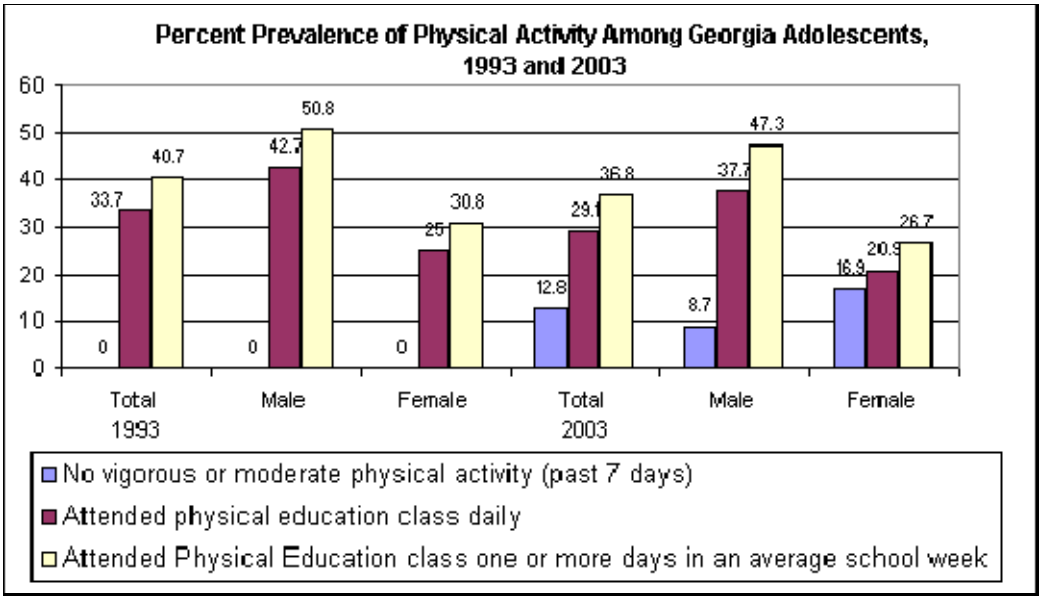
A trend similar to that seen in younger teens 15-17 years old occurred among 18-19 year olds in Georgia where a 10.9% decrease in **repeat pregnancies** was seen between 1994 and 2003. A decrease of 15% occurred among non-Hispanic Blacks, a decrease of 4.1% occurred among non-Hispanic Whites, and a decrease of 6.2% occurred among Hispanic 18-19 year olds.



Data source: http://oasis.state.ga.us/webquery/mch.html

Health Risk Behaviors Among Adolescents:

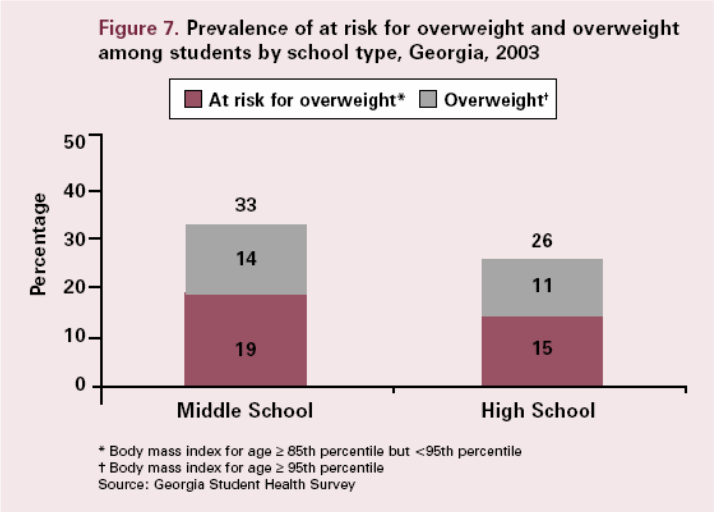
Physical Activity: In the 2003 Youth Risk Behavior Surveillance Survey (YRBS), over 10% of Georgia teens reported no vigorous or moderate activity over the past week. In addition, almost twice as many girls as boys reported not having moderate or vigorous physical activity that same year. For both males and females, the prevalence of physical activity among adolescents in Georgia seems to be decreasing.



Data source: http://health.state.ga.us/pdfs/epi/cdiee/gshsreport.0304.pdf 2003 Georgia Student Health Survey Report

Overweight: Extra weight puts youth at risk for serious health problems such as Type II diabetes, asthma, high blood pressure, and sleep apnea. The prevalence of at risk for overweight or overweight among children in Georgia is twice what would be expected for a normal population of children. In 2003, one in three middle school students and one in four high school students were at risk for overweight or overweight, based on the Georgia Student Health Survey. In middle and high school, males were more likely to be overweight than females. Black students were more likely to be overweight or at risk for overweight than White students, and White females had the lowest prevalence for at risk for overweight or overweight. The prevalence of this latter group is about half that of all other race-, sex-groups. The heaviest high school students, 35.7%, at risk for being overweight or who are overweight were Hispanic boys.

Georgia high school students report poor nutritional habits in the 2003 YRBS, at rates somewhat higher than teens nationally. In Georgia, 16.8% of youth report eating fruits and vegetables at least five times a day compared to 18.4% in the U.S., and 13% reporting drinking at least three glasses a milk a day as compared to 16.7% in the U.S.



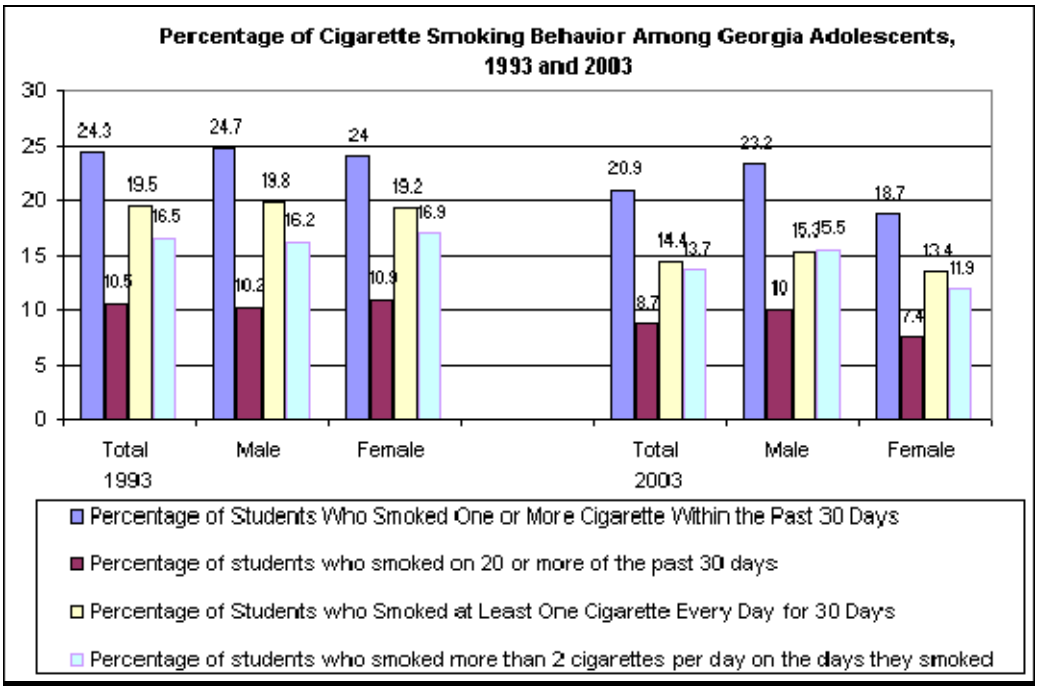
Data source: *Maternal and Child Health in Georgia Birth Through Age 5, 2004*, Division of Public Health.

Substance abuse: In general, Georgia youth report lower rates of substance abuse risk behavior than youth nationally. They consistently report risk behaviors that are one-quarter to one-third less than national data. For tobacco use, Georgia was one of six states reporting the lowest percentage of persons ages 18 to 24 using any tobacco product, and for alcohol use, was one of ten states reporting the lowest percentage of persons ages 18 to 24 using alcohol during the past month.

Although the above data paints a positive picture, Georgia youth surveyed as part of a 2000 Georgia Division of Mental Health, Developmental Disabilities, and Addictive Disease survey reported beginning to smoke at an average of 12.5 years, starting alcohol consumption at an average of 13.5 years, and marijuana use at an average age of 13.1 years. Alcohol and cigarette use dramatically increase between the ages of 15 and 18, with one-third of 18 year olds reporting alcohol use within the past 30 days. Males surveyed report higher use of tobacco products, alcohol, and marijuana than females. White youth report higher levels of smokeless tobacco, cigarettes, alcohol and marijuana than Black youth.

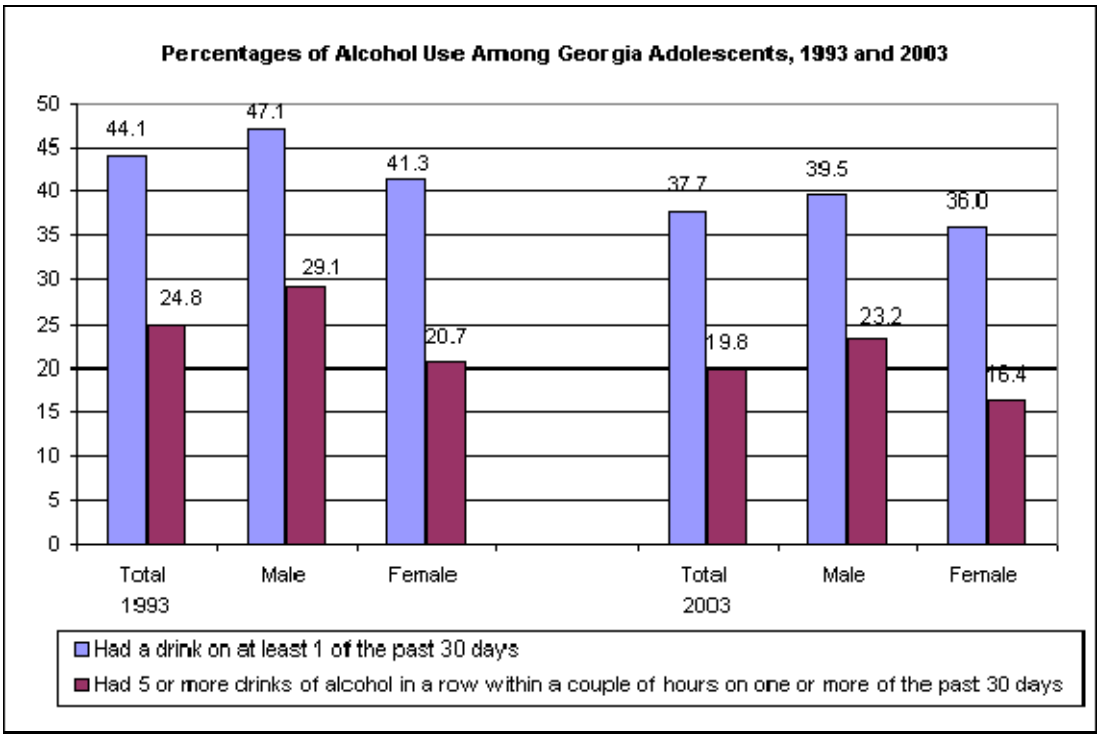
In the 2003 YRBS, 2.4% of Georgia high school students report lifetime heroin use, 7.5% report methamphetamine use, and 8.3% report ecstasy use. The percentage of males reporting lifetime use of all three substances is slightly higher than females. Approximately 7% of high school students report lifetime cocaine use and 1.8% report lifetime illegal injection drug use. These figures are somewhat lower than the U.S. rates of 8.4% and 3.2% respectively. Lifetime steroid use among Georgia youth was reported by 4.4% of teens compared to 4.8% nationally.

Between 1993 and 2003, the percentage of Georgia adolescents reporting that they had smoked at least one **cigarette** in the past month decreased by 14% and the percentage reporting they had smoked 20 or more cigarettes decreased by 17.1%.



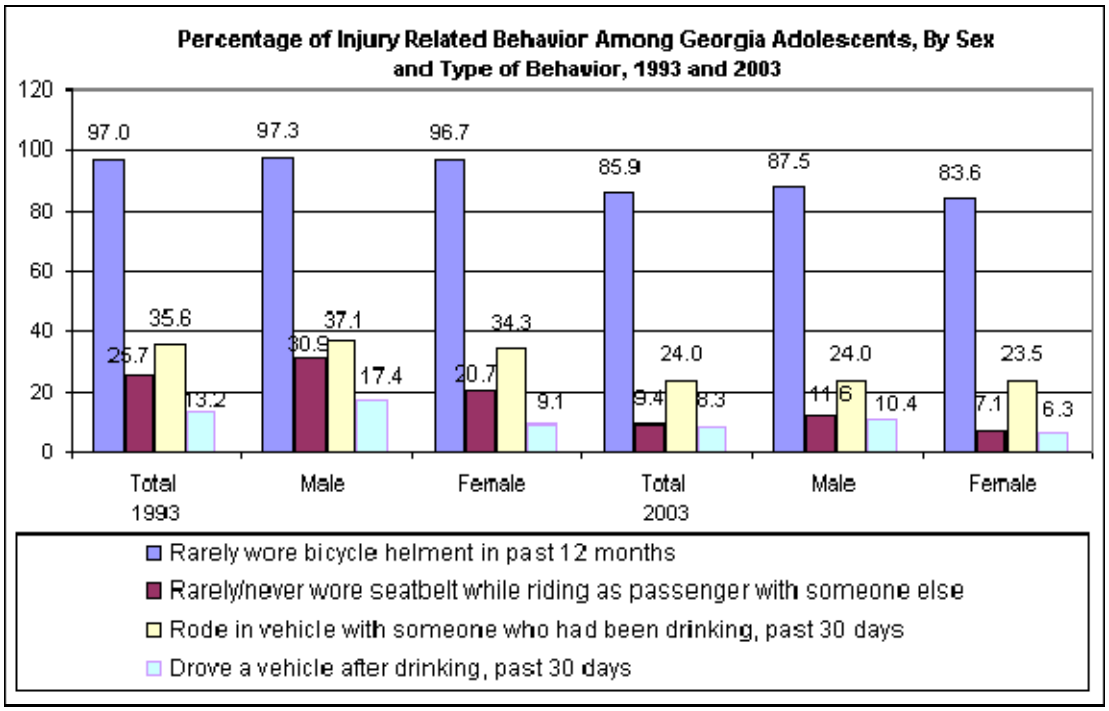
Data source: http://health.state.ga.us/pdfs/epi/cdiee/ghsreport.0304.pdf 2003 Georgia Student Health Survey Report

Based on self reported behavior in the 2003 YRBS, the number of adolescents reporting they had one or more **alcohol** drinks within the past month decreased by 14.5% between 1993 and 2003, with the number reporting that they had five or more drinks decreasing by 22.2%.



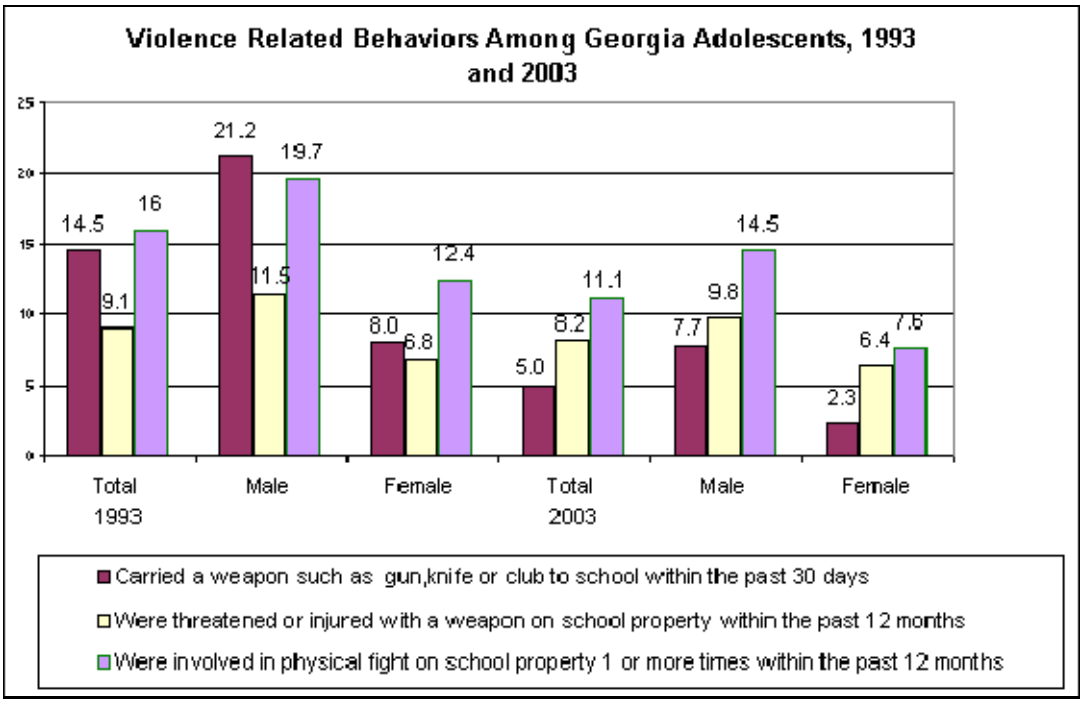
Data source: http://health.state.ga.us/pdfs/epi/cdiee/ghsreport.0304.pdf 2003 Georgia Student Health Survey Report

Injury: From 1999 to 2003, the number of adolescents who reported that they rarely or never wore a seatbelt while riding as a passenger decreased by 2.5%. In the same time period, the number of adolescents who reported riding in a motor vehicle operated by someone who had been drinking decreased by 32.6%, and the number who reported that they drove a vehicle after drinking decreased by 52.3.%.



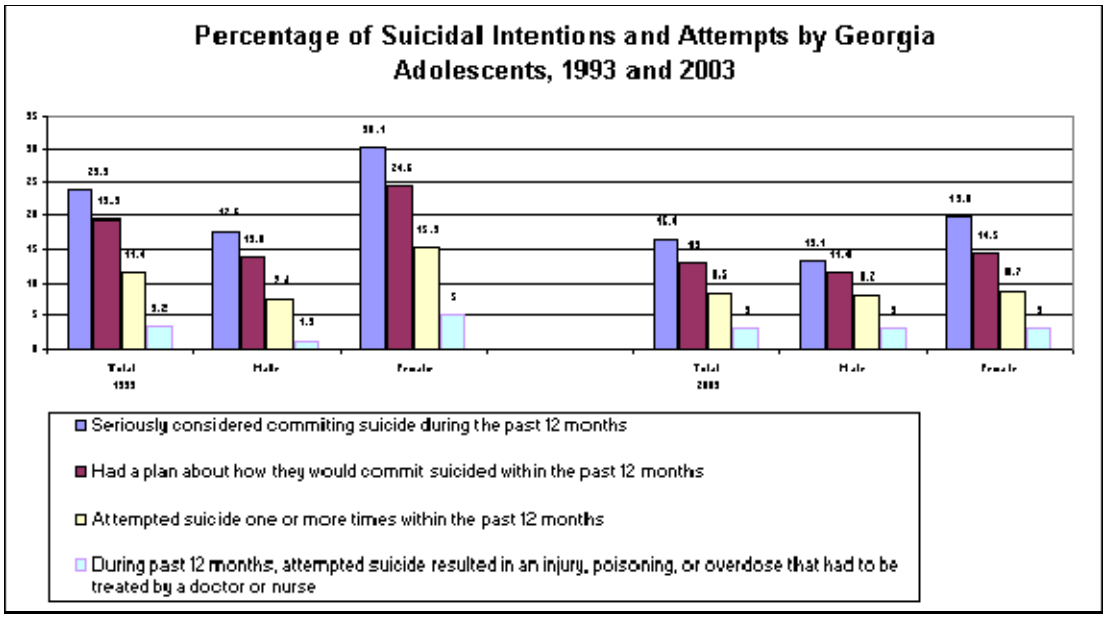
Data source: http://health.state.ga.us/pdfs/epi/cdiee/ghsreport.0304.pdf 2003 Georgia Student Health Survey Report

Violence: A major decline in the percentage of adolescents reporting carrying a weapon to school in the previous month, a drop of 86.2%, occurred between 1993 and 2003. During the same time period, 44.1% fewer teens reported being involved in a physical fight on school property in the past year and a decrease of slightly under 10% occurred in the number of adolescents who reported being threatened or injured with a weapon on school property. Fourteen percent of Georgia youth, about same in males and females, report experiencing dating violence, a rate about 40% higher than the national figure of 10%.



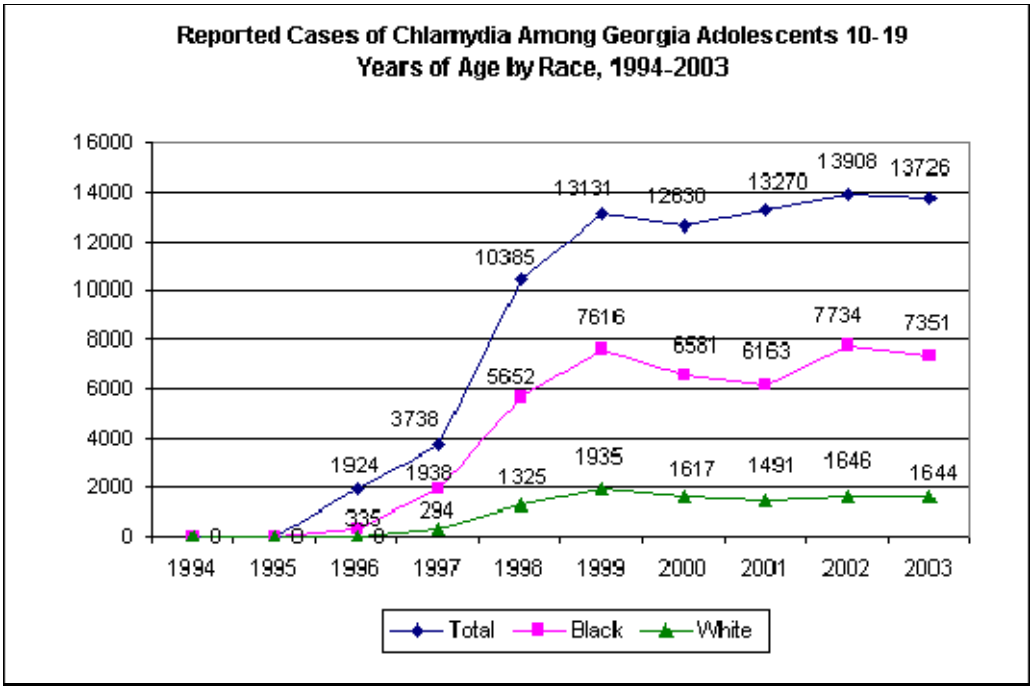
Data source: http://health.state.ga.us/pdfs/epi/cdiee/ghsreport.0304.pdf 2003 Georgia Student Health Survey Report

Suicide: The percentage of Georgia adolescents reporting that they had seriously considered committing suicide in the past year decreased by 31.4% from 1993 to 2003, and the percentage who reported actually attempting suicide within the past year decreased by 25.4% during the same period.



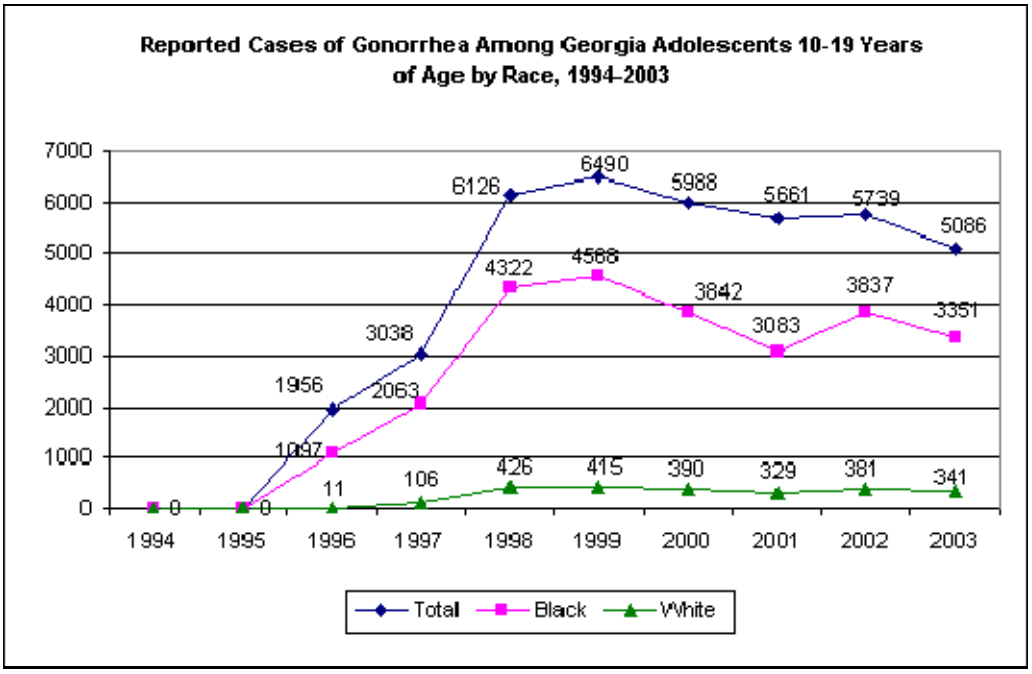
Data source: http://health.state.ga.us/pdfs/ep/cdiee/gshsreprot.0304.pdf 2003 Georgia Student Health Survey Report

Between 1996 and 2003, there was a seven-fold increase in the number of **chlamydia** cases reported in Georgia adolescents. While the increase was five-fold among White adolescents, it was almost 22-fold among Black youth.



Data source: http://www.ph.dr.state.ga.us:8090/ehi/owa/epi_run.call/query?query_type=A , Notifiable Disease Epidemiology Unit

Between 1996 and 2003, the number of reported cases in **gonorrhea** cases among teens ages 10-19 increased 2.5 fold, from 1,956 cases to 5,086 cases. The increase was 31-fold among White adolescents and just over 3-fold among Black adolescents.



Data source: http://www.ph.dr.state.ga.us:8090/ehi/owa/epi_run.call/query?query_type=A , Notifiable Disease Epidemiology Unit

High School Graduation: High school graduation helps marks the passage from teen years to adulthood. Those who graduate high school have been shown to have far greater success in their adult years and far healthier lives than those who do not. About four out of ten Georgia students who begin ninth grade do not graduate, one of the worst high school completion rates in the U.S. In 2004, the state had a 65% graduation rate, up slightly from 63% in 2003 and 61% in 2002. The rate is even lower for Georgia's Black (56.8%) and Hispanic (49.6%) students. Failure to graduate from high school has a significant impact on earning power. Approximately 27,000 Georgia teenagers drop out each year. U.S. Census Bureau data indicates that high school dropouts earn on average $18,900 compared to $25,900 for high school graduates and $45,500 for college graduates. University of California Santa Barbara's Russell W. Rumberger has estimated that as a result of teen drop outs, Georgia loses $7.3 billion a year in wage-related revenues. He also estimated that about 528 of the 27,000 dropouts will become prison inmates at a cost to state taxpayers of about $105 million. Georgia's low high school completion rate contributes to its low ranking, 48th in the nation, in the number of 18-24 year olds enrolled in higher education.

Children With Special Needs Highlights

Data on health indicators related to children with special health care needs is limited. Nationally and in Georgia, approximately one in eight children (12%) has special health care needs. Among children ages birth to five, 8% of children have special health care needs and among older children, ages six to 17, about 15% have special health care needs. Approximately 50% more males (14.9%) than females (10.4%) have special health care needs. The prevalence of children with special health care needs is highest among White children in Georgia 14.6%, compared to Black children 11.6%, and Hispanic 5.2%. Almost 27,000 children in the state were receiving SSI payments in December 2003.

An emerging concern is the increase in autism that was seen in a CDC study of 13 communities in the U.S., including metro Atlanta. In a review of records at schools, doctor offices, and social service agencies in the five core metro Atlanta counties, CDC found that one in 300 children had autism. This rate is nearly ten times higher than that found in previous U.S. studies. The rates among Blacks and Whites were the same; autistic boys outnumbered girls four to one. This increase is reflected in the over 2,000% rise in the number of children with autism in Georgia's public schools. This number went from 215 children with autism in 1993 to 4,383 children in 2003. The number more than doubled between 2000 and 2003.

There are three DPH programs that serve children with special health care needs: Georgia's early intervention program Babies Can't Wait, which serves children birth to three, Children's Medical Services (CMS), which serves children birth to 21, and High Risk Infant Follow-Up (HRIFU). Of the most commonly served Babies Can't Wait diagnoses in 2003, over one-quarter, 27.5%, had Down Syndrome, 16.% had seizure disorder, and 11.5% cerebral palsy. Approximately 6.5% of the ten most common diagnoses are children with severe hearing impairment, a condition that the Universal Newborn Hearing Screening and Intervention initiative identifies. Autism accounts for another 5% (61 children) of the ten most commonly served diagnoses among these young children.

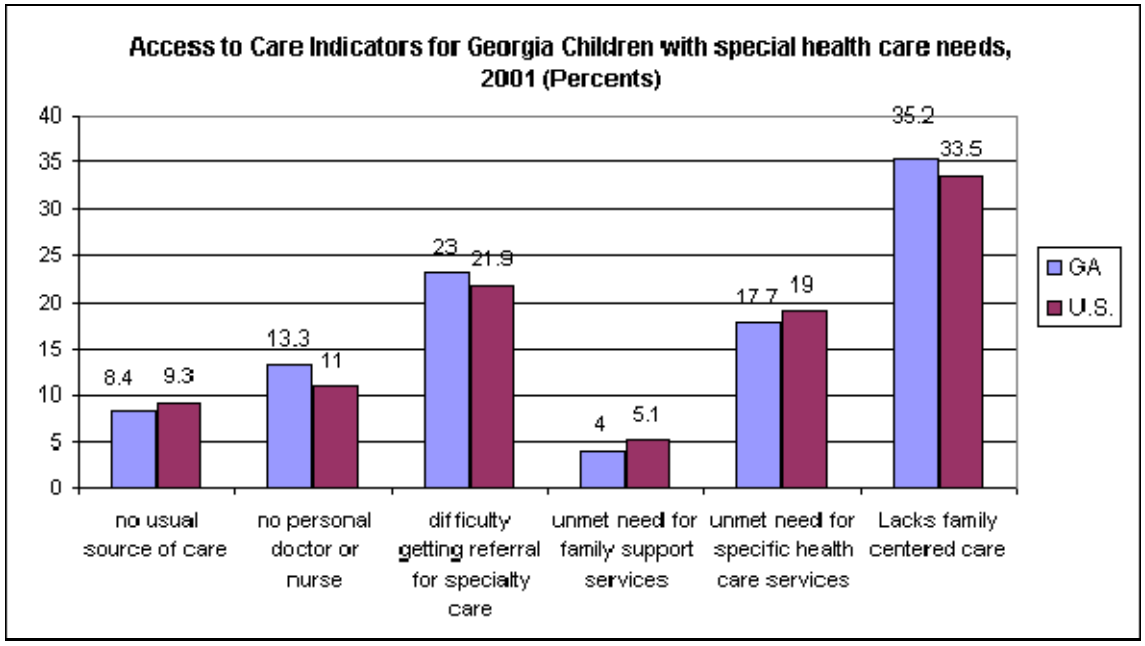
Of the almost 10,500 children served by CMS in 2003, 37% had plastic surgery/craniofacial conditions, 28% orthopedic conditions, 15% neurologic conditions, 13% hearing conditions, 6% genetic, 6% cardiac, 6% vision, 6% asthma, 5% chronic lung conditions, and 4% diabetes.

HRIFU provides care coordination to families with infants, birth to one year of age who have medical/health conditions, especially low and very low birth weight babies. During the first two quarters of SFY 2005 (July 1 – December 2004), 627 low or very low birth weight babies were newly enrolled in HRIFU. The most common diagnoses besides low birth weight babies are birth defects, such as cardiac, cleft-lip and palate, and hydrocephalus; respiratory synctyial virus (RSV); and concerns about nutrition/weight gain.

The National Survey of Children with Special Health Care Needs, which examined children ages birth to 17 years old, shows that families in Georgia are somewhat more impacted by having a child with a special health care need than similar families nationally. In Georgia, 23.7% of families report that their children's health conditions consistently and often affect their daily activities and 15.9% report 11 or more days of school absence due to illness. Georgia children with special health care needs are more likely than similar children nationally to lack insurance coverage; 12.7% reported not having health insurance at some point during the year; 3.3% were currently uninsured; and 37% stated that

their health coverage was not adequate. Examining access to care, 19% of families indicated their child had one or more unmet needs for specific health care services, and 23% said they had problems getting a referral. About one in nine families said their child did not have a personal doctor or nurse to provide care and 8.4% were without a usual source of care or relied on the emergency room. Overall, over one-third (35.6%) reported that they did not have family centered care. About one-fifth of families experienced financial problems due to the child's health needs and over one-third (37.2%) reported that family members had to cut back or stop working due to care issues related to the child.

Georgia is one of 11 states where less than 50% of families report that their child with special health care needs has an effective medical home, compared to the national average of 53%.



Data source: http://www.cdc.gov/nchs/slaits.htm

Summary of Stakeholder Input

A vital component of Georgia's 2005 MCH needs assessment was local perspective and input. Focus groups, key informant interviews, and web-based surveys were conducted that focused on needs, barriers, gaps in services, emerging issues, and what was working in Georgia's MCH system in early 2005. A total of eight focus groups were held statewide in both urban and rural locations. The groups were comprised of a cross section of MCH stakeholders, providers, and consumers including parents of children with special needs, members of the Hispanic community, parent advocates, and teens. In addition to these focus groups, key informant interviews and web-based surveys took place, which focused on needs, gaps, barriers, emerging issues, and what was working well in Georgia's MCH System. The tables on the following pages summarize the input received from these stakeholders. Identification of what is working well is also evidenced by the "Family Stories" provided in Section F: Support Documentation, Attachment 5 and by public dialogues conducted in 2003 by the Governor's Council on Maternal and Infant Health to gain insight into the critical issues that challenge the health status of the state's mothers and infants.

The dialogues, open to the public with 215 persons in attendance, were held in seven communities around Georgia. Participants attending each public dialogue were divided into discussion groups of eight to ten individuals, with Council on Maternal and Infant Health members participating in each group. At every dialogue in every part of the state, the following issues were voiced as the top five priority issues that affect Georgia's mothers and infants:

1. Premature births,
2. Teenage pregnancy,
3. Adolescent health,
4. Mental health, and
5. Oral health.

The following issues cut across all five priority areas:

1. Racial and ethnic populations,
2. Access to care, and
3. Behavioral factors.

Stakeholder Input Summary Tables – 2005 MCH Needs Assessment

Data Group	Key Informant Interview	State Program Coordinators	Consumer Focus Groups	Teens
Needs	• Oral health services for adults and children	• Oral health services	• Oral health services	• (Oral health) Dentist who know how to work with teens
	• Health care payment sources / lack of health insurance	• Medical care for uninsured, undocumented, or low income clients and families	• Convenient and affordable healthcare, i.e. insurance coverage	• Physical exams
	• Mental health services particularly for youth and in the rural areas of the state	• Mental health services	• School based health and therapy services	• Centers especially for teens to get their services
	• Perinatal services particularly for teens and adolescents	• Transportation services	• Transportation services	• Gynecological services
	• Education and prevention services	• Translation services	• Culturally and linguistically appropriate services	• Prevention focus for youth – changing behaviors long term

Data Group	Key Informant Interviews	State Programs Coordinators	Consumer Focus Groups	Teens
Barriers / Challenges	• Lack of culturally and linguistically appropriate services	• Lack of translation services / language barriers	Racial disparities	• Parents -- who do not want to provide teens with health education
	• Lack of service capacity especially around mental health services for youth and adolescents, and oral health	• Staffing difficulties in recruitment and retention. High staff turnover	• Case managers are overloaded	• Lack of centers to provide care in a non-threatening environment
	• Decrease in or lack of funding for services and programs	• Reduction in or lack of funding for programs	• Caps on services	• Lack of funding for services and programs for teens
	• Lack of Transportation services	• Transportation services	• Access to services if you are not pregnant or employed	• Confidential services – teens maybe afraid to seek information they need for fear their parents will be told
	• Relationship building and maintenance		• Public is not educated on services that are available	• No insurance/ no money

Data Group	Key Informant Interviews	State Programs Coordinators	Consumer Focus Groups	Teens
Gaps in Services	• Lack of services in the rural areas, i.e. oral health, mental health, and OB GYN services	• Referral services for uninsured and foster care patients	• Oral health services	• Instability with providers – teens need to be able to build trust and relationships with providers
	• Lack of health services payment sources / health insurance	• Lack of translation services	• In-home services and therapies for CSN	• Parents and adult don't understand why it is important for youth to have health education
	• Culturally and linguistically appropriate services	• Services for undocumented populations	• Mental health services	• Lack of mental health services for youth - when they are thinking of suicide or have problems with drugs
	• Communities, providers, and agencies are unaware of what programs and services are available	• Immunization services	• Health education	• Need to improve how the health department works with high schools relating to health education messages
	• Transportation services		• Male services	

Data Group	Key Informant Interviews	State Programs Coordinators	Consumer Focus Groups	Teens
Emerging Issues	• Medicaid Managed Care Services	• Medicaid managed health services	Consumers were not questioned about emerging issues.	
	• Obesity and related health issues	• Obesity and associated diseases-CVD, hypertension		
	• Increasing immigrant populations, especially Latino population	• Increasing immigrant populations		
	• Increasing Cost of Healthcare	• Increasing undocumented population		
	• Funding cuts to health services	• Aging population		
What is Working Well	• WIC	• WIC	• WIC	School health nurse works closely with the teen program at the health department
	• Teen Centers	• Local public / private partnerships	• Teen Centers	Teen Centers .
	• Local Health Initiatives and Partnering	• Direct health care services	• Family planning services	
	• Health Education		• Breastfeeding coordination	
	• School-based Services			

Levels of the Pyramid

As part of the needs assessment process, each FHB population team examined the services that fell within its realm of responsibility according to the four levels of the pyramid. In this assessment, each team assessed existing resources, gaps and barriers, existing enabling services, gaps in enabling services, and the role that the FHB is currently playing as well as the role that the Branch should be played. A matrix, reflecting their findings, was developed for each population group, with separate matrices for nutrition and oral health, which cut across all groups. (See Section F: Attachment 6 for completed matrices.) These matrices provide a basis for looking at what ought to be as contrasted with the current status of MCH services in Georgia. The major conclusions related to this process, grouped by population, are below.

Women: Health related concerns include the impact of STDs, prevention of pre-term delivery, reproductive health services for disabled women, depression, obesity, and health disparities. Policy concerns focus on parental consent for teen services and cultural competence of health care providers.

Infants and Children: Several key issues were identified related to infants and children. A major concern is inadequate community-based services and/or providers, in some areas, to meet the needs of children identified through various screening programs. Also, meeting the needs of an increasingly multicultural population, both in terms of public awareness and outreach activities as well as direct clinical service delivery, was noted for increased attention.

Adolescents: The targeting of youth development programs and activities focused on sexually active and pregnant and parenting adolescents was seen as a major issue. In addition, the need for more resources for preventive case management was noted. A concern was expressed about fire arm safety issues in this age group. Emerging issues include, once again, the need to address the needs of the state's increasingly diverse adolescent population and a better meshing between the public and private health sectors, particularly focused on school health.

Children with Special Needs: Family transportation to services, both local and longer distance for specialty care, are needed. Cutting across all population groups, issues related to serving an increasingly multicultural population were raised. A particular issue for families with children with special needs was difficulty related to family involvement and compliance with recommendations resulting from language barriers and cultural influences. Inadequate reimbursement rates for children with special needs providers is a barrier. These providers, who must have a more specialized knowledge base, spend more time evaluating and working with these children, who often have more needs and more complex needs, and require more services. The lack of emphasis and knowledge about prevention of secondary conditions associated with primary conditions of children with special needs and risk reductions behaviors to deal with adolescents with special needs is also a concern. Specific family needs raised are lack of child care, respite care, and care in the school system, as well as services that address the emotional and mental health needs of children with special needs and their families.

C. Needs Assessment Summary

Based on Georgia's 2005 MCH needs assessment findings and emerging trends (described in Section B.), the FHB selected the ten priorities listed below to provide the framework guiding the state's MCH planning and policy development over the next five years. Proposed state performance measures are listed under each priority area.

Priority 1: **Assure early access to prenatal & postpartum care for pregnant women**

SPM 1: Percentage of pregnant women who abstain from smoking.

Priority 2: Promote healthy nutritional behaviors and physical activity among the MCH populations

SPM 2: Percentage of high school students who participated in physical activity for at least 20 minutes on 3 or more of the past 7 days.

Priority 3: Reduce unintentional and intentional injury among MCH populations.

SPM 3: Rate of hospitalizations due to unintentional injuries among children ages one through five.

Priority 4: Improve oral health among MCH populations.

SPM 4: Percent of Medicaid and PeachCare (S-CHIP) enrolled children who received preventive services.

Priority 5: Promote peconceptional health.

SPM 5: Percent of women of reproductive age who consume at least 400mcg of folic acid daily.

Priority 6: Promote healthy behaviors and reduce risk-taking behaviors among Adolescents.

SPM 6: Percentage of repeat pregnancies among Adolescents aged 15-17-years-old.

Priority 7: Reduce health disparities among MCH populations.

SPM 7: Ratio of SIDS and SUIDS among African American infants to white infants.

Priority 8: Assure a comprehensive system of age appropriate screening, referral, and follow-up from birth through age 21.

SPM 8: Percentage of Medicaid children who have had a developmental screening.

Priority 9: Assure an adequate MCH workforce.

SPM 9: Percentage of MCH local level staff that receive basic Public Health training.

Priority 10: Engage in partnerships that support comprehensive systems to improve the health of MCH populations.

SPM 10: The extent to which partnerships that support Early Childhood Comprehensive Systems (ECCS) are effective.

Proposed State Outcome Measure: Rate of Type 2 diabetes among African American and Hispanic Medicaid population ages 1 through 20.

Summary of the process used to determine Georgia's priority needs and the how collaborative efforts contributed to the selection of the priority needs: A half-day meeting was called to reconvene the Needs Assessment Advisory Committee (See Section F: Attachment 3 for advisory group membership) for the purposes of presenting the findings of the needs assessment and for setting the new ten state priorities. The advisory committee developed 19 draft priorities. The draft priorities were disseminated via email to all members of the advisory committee, management team, and key informants who were asked to vote for their top ten priorities. Once the voting was completed, the state priorities were finalized through discussions between the management and core teams.

The FHB planners were engaged to develop new state performance and outcome measures based on the findings of the needs assessment and the state priorities. Working with the Branch's Data Team and the Policy Planning and Evaluation Section, the FHB planners looked at specific needs and priorities related to each level of the MCH pyramid in an effort to develop performance and outcome measures that were both measurable and meaningful to the work of the Branch. Because of the six existing CSHCN National Performance Measures, FHB decided against creating a new CSHCN specific state performance measure. Draft performance and outcome measures were developed and disseminated among population teams, sections, FHB and MCH Epi leadership. These groups and individuals were asked to vote for their top three measures for each state priority. PPE staff tallied votes to determine the top ten state performance measures and one state outcome measure.

How Georgia's analysis of need by MCH population group pointed to the priority needs selected: Georgia's 2005 MCH needs included an in-depth environmental scan as well as the collection and analysis of key MCH population health status data. (See Section B. for needs assessment findings.) The assessment identified gaps, barriers, needs, current capacity, what is working well, and what are the emerging trends. Certain aspects of the needs assessment against which the ten new priority measures were developed included the changing roles of the health departments, changing population demographics, the changes taking place in Georgia's political environment, impact of Medicaid managed care, changes in Medicaid eligibility, and emerging issues such as reduced access to care and the rising teen birth rates in the Hispanic population.

Key needs assessment findings included the following:

DEMOGRAPHICS

Changing Population Dynamics

- Georgia population is **growing and diversifying rapidly** and is currently at nearly 8.7 million people. The largest percent increase has been among Hispanics and Asians. In 1990, 1.7% of Georgia's population was Hispanic, compared to 5.3% in 2000. Although the percent increase was larger among Hispanic and Asian populations, numerically the increase among the African-American population was higher.

- Georgia's **population continues to be younger** compared to the U.S. as a whole, ranking 6th in terms of lowest median age in 2000.

- Between 1994-2003 both the urban and rural populations grew while the **urban population increased more rapidly**. Georgia has doubled the number of MSAs from 7 to 14 between 1990 and 2000, increased the number of counties included in the Atlanta MSA and others, and doubled the number of counties designated as suburban from 27 to 53.

Poverty and Health Care Coverage

- The percent of **children under the age of 5 living in poverty increased** to 21% in 2003 compared to 18.7% in 2000. Single women headed more than half of these households.

- Georgia's $1.9 billion Medicaid budget makes up about 12% of the current state budget. **Medicaid currently insures 1.5 million poor and disabled Georgians, while PeachCare provides coverage to 200,000 uninsured children**.

- Georgia ranks ninth nationally in the total number of uninsured residents and 14th in terms of proportion of uninsured residents (16%). **The number of non-elderly non-insured Georgians has increased 20%** since 2000. **Racial and ethnic minorities and rural residents are much more likely to be uninsured**.

Health Delivery System

- Nearly 299,000 workers, **7.7% of Georgia's total workforce, were employed in the health sector in 2000.** This ranks Georgia 37th per capita health services employment.

- **The demand for health professionals** in Georgia is **projected to grow by 37% by 2010**. The Georgia Department of Labor predicts a need for more than 140,000 new and replacement health care professionals, including about 30,000 additional RNs, 9,000 LPNs, 3,700 pharmacists, and thousands of allied health and behavioral health professionals.

- Georgia's problem with **maldistribution of providers** continues to impact access to care, particularly for uninsured and underinsured persons and residents of rural areas, especially those requiring specialty care. There are **too many providers in urban areas and not enough in rural parts of the state. Specialty care is more limited**, generally located in
- areas with academic medical centers (i.e., Atlanta, Augusta, Macon and Savannah), leaving large portions of the state without access to this care.

- Presently, services are provided through a gatekeeper model, Georgia Better Health Care, in which a primary care case manager authorizes patient services. In order to control escalating costs, **DCH is moving to a managed care system for Medicaid/ PeachCare enrollees**. The Georgia Care Program, which will be phased in between January 2006 and January 2007, will cover low income families, transitional Medicaid, pregnant women (presumptive), pregnant women (Right from the Start) – RSM, RSM children, newborns, PeachCare for Kids, and women eligible for Medicaid due to breast and cervical cancer.

- As public health enters this new state fiscal year, **several emergent issues will impact Georgia's local public health service delivery system**. County grants-in-aid, which are state funds provided to each county health department to support overall operations, are planned for reallocation, based on more recent population figures. The county boards of health are also being confronted with the potentially significant but still unknown impact related to the implementation of Medicaid managed care. Approximately 25% of current county health department revenues are derived from Medicaid/PeachCare. Also, a state needs assessment for Public Health indicated increased emphasis on core functions.

WOMEN

Mortality and Morbidity

- The **rate of maternal mortality is about three times higher among Black women** than white women. The maternal mortality rate among Black women was 37.5 per 100,000 live births in 2002 compared to 12.9 for White women. Both groups have rates well above the Healthy People 2010 goal of 3.3 per 100,000.

- The **leading cause of death among women ages 15-34 is unintentional injury**. The second leading cause of death among women ages 15-24 is homicide while the second leading cause of death among women ages 25-34 is cancer.

- Of the 3,456 cumulative female **AIDS cases** that have been reported between 1981-1999 among Georgia females, 85% **were among minorities**.

- The **rate of Diabetes among women 20-44 increased** from 111 per 100,000 to 127 in 2002. Black diabetes morbidity rates are 2.5 higher than white rates.

- **Minorities increasingly account for a larger proportion of female AIDS cases** since surveillance of AIDS began. In 1985, minorities accounted for 64% of female AIDS cases; this increased to 88% in 2001.

Reproductive Health

- **Georgia's fertility rate remained steady between 1994-2003**. In 2003, the overall rate was 69 births per 1,000 females ages 15-44. While the rates remained relatively steady for Non-Hispanic White and Black women, the **rate has increased significantly for Hispanic women** from 99 in 1994 to 153 in 2003.

- The **percentage of pregnancies that were reported as unintended decreased** from 48% in 1995 to 42% in 2000.

- In 2003, **about 11% of all pregnant women received an inadequate level of prenatal care**. Prenatal care varies by race and ethnicity. About 7% of Non-Hispanic white women, 15% of Non-Hispanic Black women, and 22% of Hispanic women received inadequate prenatal care in 2003.

- In 2002, the percentage of women reporting taking the **recommended amount of folic acid was 37% among 18-24 year olds**, 48% among 25-34 year olds, and 54% among 35-44 year olds.

- **Breastfeeding prevalence** among WIC participants was **highest among Hispanic women** at 74% and lowest among Non-Hispanic Black women at 40%. **With increasing age of the mother, the likelihood of breastfeeding increases for WIC participants.**

Chronic Disease Risk Behaviors

- In 2002, more than **half of all women in Georgia (53%) were either overweight or obese**. The percentage of obesity among women in Georgia increased from 17% in 1994 to 24% in 2002.

- **About one-fifth of Georgia women over 18 years of age reported being current smokers in 2002**, above the Healthy People 2010 goal of 12%.

INFANTS

Mortality and Morbidity

- The **infant mortality rate in Georgia** was 8.5 per 1,000 live births in 2003 **higher than the U.S. rate** of 6.9 (preliminary). Both in the U.S. and in Georgia **infant mortality rates have been slightly increasing** for the first time since these data have been collected. This increase has been associated with an increase in prematurity.

- **Black infant mortality rates are more than twice that of white rates** for deaths during the neonatal period (0-28 days) and the postneonatal period (29-365 days). The leading causes of death during the neonatal period are prematurity/low birth weight and congenital anomalies while the leading cause of death during the postneonatal period is SIDS. Hispanic and Infants of "Other races" have lower infant mortality rates that Non-White Hispanics.

- In 2000 and 2001 the **two leading congenital abnormalities** among infants in Georgia were **heart malformations and cleft lip palate**. **Down's syndrome**, the third most common congenital abnormality **increased by 21.2% from 2000 to 2001**.

- Between 1997 and 2003, the **percentage of newborns screened for hearing prior to hospital discharge increased almost three-fold** from 32% to 95%.

CHILDREN

Mortality and Morbidity

- The **leading cause of death for children ages 1-9 is unintentional injury**, accounting for 43% of all child deaths from 1999-2002.

- Asthma is a leading cause of school absenteeism. Between 1999 and 2002, the rate of hospital discharges due to **asthma increased by 12% for children ages 1-22**. The rate of **asthma hospitalizations is nearly twice that for black children** at 312 per 100,000 compared to 172 per 100,000 for white children.

- **Type 2 diabetes has been increasing among children**. The rate of hospital discharges due to diabetes increased by 52% among black children and 16% among white children.

- **Oral health issues also pose a challenge to school success**. Georgia ranked 23rdth out of 50 states in number of dentists per capita.

- **The number of substantiated reports of child abuse and neglect rose by 88%** from 16,024 to 30,037 between 1999 and 2004.

- Between 1997 and 2004 the **percentage of children under age 2 who were completely immunized rose** by 7.2% from 75% to 80%.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

- The **percent of children with special health care needs (CSHCN) was 12.7%** in 2001which was comparable to the national rate of 12.8%.

- In 2001, 35% of **families with a child with a special health care need** reported that they **had no access to family centered care**, 23% reported **difficulty getting referral for specialty care**, 19% reported **unmet need for specific health care services**, and 11% reported **unmet dental care needs**.

ADOLESCENTS

Mortality and Morbidity

- **The leading cause of death among children age 10-19 is unintentional injury**, representing 50% of all deaths from 1999-2002, followed by intentional injuries (suicide, homicide).

- **Half of all injuries (unintentional and intentional) are caused by motor vehicle crashes**. In the five years from 1999-2003, 926 adolescents 13-19 died as a result of motor vehicle crashes.

- **From 1993 to 2003 fewer adolescents reported engaging in risky motor vehicle related behaviors**. In 1993 25% of high school students reported rarely or never wearing a seatbelt compared to 9% in 2003; and 35% reported riding in a vehicle in the past 30 days with someone who had been drinking in 1993 compared to 24% in 2003. **Males are more likely than females to engage in these risky behaviors.**

- **From 1993 to 2003 fewer adolescents also reported engaging in violence-related behaviors**. In 1993, 14.5% of high school students reported that they carried a weapon to school compared to 5% in 2003. In 1993, 16 percent of high school students reported getting in a physical fight at school in the past year compared to 11% in 2003. **Males are more likely than females to engage in violent behaviors.**

- **Suicide represents 9% of all deaths to adolescents ages 10-19.** The percentage of high school students reporting seriously considering suicide during the previous 12 months decreased from 24% to 16% between 1993 and 2003. In 2003, 35% of females and 22% of male high school students felt sad or hopeless in the last year. **Georgia ranked 48th of all states for psychologists per capita and 47th for social workers per capita.**

Reproductive Health

- **Overall rates of first teen pregnancies, repeat teen pregnancy, and teen births have gone down** in all age groups and for non-Hispanic White and Black adolescents. However the **rates have been increasing for Hispanic adolescents**. Among 15-17 year olds, while the total teen pregnancy rate declined 41% from 68 per 1,000 live births to 40, the Hispanic teen pregnancy rate among 15-17 year-olds increased 62% from 63 to 102.

- While Georgia has experienced significant declines in **teen pregnancy the rates remain above national rates**. Georgia ranked 45th for teen births among 15-17 year-olds in 2001. About 16% of pregnancies among 15-17 year-olds are repeat and more than one-third of pregnancies among 18-19 year-olds are a repeat.

- **Reported cases of Chlamydia have been rising** among Georgia adolescents ages 10-19 from 10,385 cases in 1998 to 13,726 cases in 2003. Reported **cases are significantly higher among black adolescents** with 7,351 reported cases in 2003 compared to 1,644 among white adolescents. At the same time, **cases of Gonorrhea have been declining among adolescents**.

Chronic Disease Risk Behaviors

- **Young people are not eating the recommended servings of fruits and vegetables.** Seventeen percent of high school students consumed the recommended five servings of fruits and vegetables per day.

- **One third of middle school students are overweight or at risk for overweight and one fourth of high school students are overweight or at risk for overweight.** Fourteen percent of middle school students are overweight and 19% are at risk for overweight. Among high school students, 11% are overweight and 15% are at risk for overweight. In addition, **more than half of middle school students and 42% of high school students watch 3 or more hours of television per school day**.

- **The number of high school students who reported smoking at least one cigarette during the past 30 days ("current smokers") has gone down**. In 1993, 24% were current smokers, as compared to 21% in 2003.

STAKEHOLDER INPUT

- Key informants, state program coordinators, consumer focus group participants, and teen participants all identified **oral health services as a priority need**.

- **Other identified needs** included perinatal services, particularly for teens and adolescents, mental health services; translation services; culturally and linguistically appropriate services; education and prevention services; medical care for uninsured, undocumented, or low income clients and families; and prevention focus for youth – changing behaviors long term.

The 2005 needs assessment findings confirmed the overarching themes identified in the previous MCH needs assessment. These themes, described below, cut across MCH populations and levels of the pyramid. They provide the structure that has both guided the Branch's work for the last five years and will continue it over the next five years.

Population and Social Dynamics - With the changing "face" of Georgia, both in terms of size and diversity, issues related to allocation of resources and provision of relevant services must be confronted by policy-makers and service providers. Of particular note are concerns related to non-English speaking clients and limited English proficiency (LEP) clients, which necessitate changes in staff knowledge, skills, and abilities, and in staffing patterns, program content, and policies.

Prevention – In all of its types – primary, secondary and tertiary – policies and programs need to be measured against a prevention yardstick. Preventable morbidity and mortality interventions start with the promotion of healthy lifestyles and safe behaviors. Over time, attainment of the FHB goals focused on these efforts will be reflected by improvement in Georgia's health status indicators.

Injury Prevention – Primary prevention of both unintentional and intentional injuries is a key issue impacting all MCH population groups. Both in terms of morbidity and mortality, the toll of injury in the MCH population has been understressed and underfunded.

Coordination and Collaboration – While the multiple partners and stakeholders in the MCH system are all working towards the same goal – healthy and self sufficient families – they tend to do so in a fragmented and isolated manner. Opportunities for coordination and collaboration exist in terms of program planning and implementation, personnel, research, data and advocacy.

Quality and Appropriate Service – From planning to implementation to evaluation, the quality and appropriateness of services need to be at the center of attention. At the planning stage, activities should be based on existing data, focused research, and/or successfully evaluated models. Measures for quality assurance, benchmarking, and outcome and impact evaluation

should be incorporated throughout. Training and technical assistance play key roles in assuring that services are of greatest benefit to clients and their families.

Access and Utilization – A number of barriers exist related to service access and utilization, including lack of interpretative services, reliable transportation, knowledge about existing services, available and affordable child care, accurate perceptions regarding eligibility, oral health services, and mental health services. Enabling services and resources that facilitate consumer use of MCH system services are required to reach target populations. The lack of or inadequate availability of enabling services or resources is an ongoing concern, particularly in many rural areas of the state.

Data Systems – A critical role exists for the FHB in ensuring the collection and dissemination of quality data. Moreover, the data must be transformed into information and knowledge for state and local decision-makers and opinion-leaders. With the advances in information technology, greater opportunities exist to use this technology to support the collection, warehousing, and use of data in MCH planning, policy development, service delivery, and evaluation.

D. Health Status Indicators

In conducting its 2005 MCH needs assessment, Georgia utilized a number of MCH health status indicators in assessing the health status of its MCH populations. See Section B. – Five Year Needs Assessment: Overview of the Maternal and Child Health Population's Health Status above for specific health status indicators that Georgia incorporated in its assessment. Data is also provided on Forms 20 and 21 of the state's web-based FY 2006 MCH Block Grant application.

E. Outcome Measures

Outcome Measure #01 - The infant mortality rate per 1,000 live births.
Between 1994 and 2003, Georgia's infant morality rate decreased 15% from 10.1 per 1,000 live births to 8.5 per 1,000 live births compared to a rate of 6.9 nationally. The state's overall infant mortality rate is almost twice the Healthy People 2010 objective of 4.5.

Outcome Measure #02 – The ratio of black infant mortality rate to the white infant mortality rate.
From 1994 to 2003, the infant mortality rate for Black infants decreased 11.5% from 15.7 per 1,000 live births to 13.9, less than the U.S. preliminary rate of 14.1 per 1,000 live births. During this same time period, the infant mortality rate for White infants decreased 8.9% from 6.7 per 1,000 live births to 6.1, compared to the 2003 U.S. preliminary rate of 5.8 per 1,000 live births. Despite progress in decreasing infant morality in the state, the rate of Black infant mortality in Georgia is still more than double that of White infants. It should also be noted that Georgia's Hispanic infant mortality rate has increased 21.4% since 1994, increasing from 4.2 per 1,000 live births to 5.1 in 2003. Although the rate has increased, the state's Hispanic infant mortality rate is closest to Healthy People 2010 objective of 4.5 per 1,000 live births.

Outcome Measure #3 – The neonatal mortality rate per 1,000 live births.
Georgia's neonatal mortality rate decreased 10.9% during the period 1994 to 2003, decreasing from 6.4 per 1,000 live births to 5.7. The 2003 U.S. preliminary rate is 4.7 and the Healthy People 2010 objective is 2.9. The neonatal mortality rate for non-Hispanic White infants decreased 2.5% from 4. to 3.9 per live births during the ten-year period. The rate for non-Hispanic Black infants decreased 8.8% from 10.2 to 9.3.

Outcome Measure #4 – The postneonatal mortality rate per 1,000 live births.
During the period 1994 to 2003, Georgia's postneonatal mortality rate decreased 24% from 3.7 per 1,000 live births to 2.8, compared to the 2003 U.S. preliminary rate of 2.3. The rate for non-Hispanic White infants decreased 19%, from 2.6 to 2.1. The postneonatal rate for non-Hispanic Black infants decreased 16.4% during the ten-year period, from 5.5 to 4.6. The rate for Hispanic infants fluctuated during the ten-year period, but has also decreased, from 1.6 to 1.4 and is closest to the Healthy People 2010 objective of 1.2 per 1,000 live births.

Outcome Measure #5 – The perinatal mortality rate per 1,000 live births.
Perinatal mortality includes fetal deaths of 28 weeks or greater gestation plus early neonatal deaths (less than seven days after birth). The perinatal mortality rate has remained quite steady between 1999 and 2003, increasing from 8 per 1,000 to 8.1 per 1,000 during this period. The Georgia rate is 17% higher than the national rate of 6.9 in 2002. The Healthy People 2010 target is 4.5.

Outcome Measure #6 – The child death rate per 100,000 children aged 1 through 14.
Georgia's child death rate has decreased by 16% from 27.4 in 1999 to 22.9 in 2003.

<u>Outcome Measure #7</u> – The percentage of students who graduate from high school on time. About four out of ten Georgia students who begin ninth grade do not graduate, one of the worst high school completion rates in the U.S. In 2004, the state had a 65% graduation rate, up slightly from 63% in 2003 and 61% in 2002. The rate is even lower for Georgia's Black (56.8%) and Hispanic (49.6%) students. Approximately 27,000 Georgia teenagers drop out each year. Georgia's low high school completion rate contributes to its low ranking, 48th in the nation, in the number of 18-24 year olds enrolled in higher education.

F. Supporting Documentation

Attachment 1: Needs Assessment Documents

Attachment 2: Needs Assessment Flow Chart

Attachment 3: MCH Block Grant Needs Assessment 2005, Quantitative Data – Sources

Attachment 4: Needs Assessment Advisory Group Membership List

Attachment 5: Family Stories

Attachment 6: Levels of the Pyramid Matrices

Attachment 7: Acronyms

Attachment 1 – Needs Assessment Documents

Work Plan Date: January 2005 – July 2005

Project Purpose: The purpose of this project is to conduct a statewide needs assessment that will identify the needs for preventative and primary care services for pregnant women, mothers, and infants; preventative and primary care services for children; and services for CSHCN.

Project Goals:

- Strengthen partnerships and collaborative efforts between federal, state, and local MCH stakeholders.
- Assure a connection between State MCH priorities and national MCH priorities.

Needs Assessment Objectives:

- Identify the specific needs of the state MCH population.
- Examine the capacity of the state to provide services by each level of the MCH pyramid (direct services, enabling services, population-based services, and infrastructure–building services).
- Selection of state priority MCH needs to receive targeted efforts for improvement.
- Set state-negotiated performance measures to be monitored; set outcome measure targets
- Collect and document qualitative and quantitative data for the MCH Title V Block Grant's 5-year needs assessment

Project Leadership

Eddie Towson will have lead responsibility for the needs assessment process. Specific responsibilities and tasks will be delegated to staff as project progresses.

Activities	Staff Eddie as Lead on all Activities	Indicator(s)	Timeline	Status
Develop Data Collection Tools 1. Develop data collection documents that include face-to-face and phone interview tools, focus groups for public and coordinators, web-based survey for stakeholders. 2. Include Process questions in the survey for evaluation purposes. 3. Provide appropriate training to surveyors (interns)	1. Kathleen Kinsella and Bina Philip with help from interns as needed. 2. Kathleen and Bina 3. Kathleen, Bina, Eddie	Development of actual tools (Survey questions, focus group questions)	January 31st January 31st Feb 4th	Completed Completed Completed
Evaluation Component **1.** Completed evaluations at the end of major planning meetings **2.** Develop evaluation for focus groups 3. Create Evaluation Summary Report 4. Evaluation of data collections practices	1. Eddie 2. Eddie / Rhonda 3. Eddie / Rhonda 4. MCH Epi	1. Evaluation Forms 2. Evaluation Forms 3. Evaluation Report 4. Evaluation Report	Ongoing Feb 4th May 1st May 1st	Ongoing
Pilot Instruments Pilot face-to-face and phone interviews, make the required revisions	Richelle Wright	Report on pilot results and Revisions made	February 11th	Completed

Activities	Staff Eddie as Lead on all Activities	Indicator(s)	Timeline	Status
Literature Review • Conduct a review of MCH literature pertaining to Georgia's MCH population • Summarize the information	Deb Bauer, Contractor	State Overview portion of MCH Block Grant	June 1st	Ongoing
Data Collection 1. Develop master list of both external and internal MCH Data Resources	Bina / Interns	Resource List	Jan-Feb Jan 31st	Completed
2. Documentation of qualitative data sources for environmental scan report.	Eddie, Rachel, Deb	Resource List	Feb 28th	Completed
3. Documentation of quantitative and qualitative data collection as well as all methodology.	Eddie /Interns	Summary Report	March 4th	Completed
4. Develop Protocols for conducting focus groups and key informant interviews	Eddie	Protocol document	Feb 1st	Completed
5. Coordination of 6 focus groups throughout Georgia consisting of approximately 80 total family members, parents, family advocates, and FHB planners to discuss barriers and supports to provision of services. (See Attachment A)	Richelle Wright (intern)	Master list of focus groups and summary report	Feb 28th	Completed Completed
6. Coordination of 6 program coordinator focus groups throughout Georgia to discuss needs, barriers, and supports to provision of services.	Kathleen and Rachel		Feb 28th	Completed

7. Summarize the focus group findings and themes	Deb		Feb 28th	Completed
8. Coordination of at least 30 Key Informant interviews with family health stakeholders throughout the state to discuss trends and issues in family health. (See attachment B)	Interns and Interviewers	Master List of Completed Interviews	March 15th	Completed
9. Summarize the key informant findings and themes	Eddie, Kathleen	Summary one pager	March 21st	Completed
10. Web placement of Stakeholder survey on DCH and PH websites	Eddie and Lee	Web link	Feb 11th	Completed
11. Dissemination of web link to stakeholders.	Eddie	Web link	Feb 14th	Completed
12. Development of report (using existing template) that will provide synthesis and analysis of survey data collected from web survey	DHR web team	Summary Report	March 9th	Completed
13. Coordination and/or facilitation of at least three bi-weekly meetings to share progress and ideas with needs assessment team or select students.	Interns	Scheduled Meetings held	Ongoing	Completed
Analyze Data				
1. Analyze qualitative and quantitative data, summarize observations	PPE, Data, Interns, Contractor	Ongoing data summary and analysis	March Feb 28th	Completed
2. Review qualitative data and summarize into theme one pagers and determine basic themes from qualitative data analysis	PPE, Data, Interns	One pagers presented to Analysis group	March 21st	Completed

• Coordinator Focus Group and Coordinator Questionnaire data	Bina, Rachel, Dalene, Richelle			Completed
• Key Informant Interviews and Survey data	Eddie Kathleen			Completed
• Consumer Focus Groups	Eddie, Elana, Gala			Completed
3. Develop Quantitative and Qualitative Data Summary document based on discussions with Data, PPE, and other staff as needed.	Bina and interns	Summary Document	April 7th	Completed
4. Review, summarize, and detail key findings of all data (qualitative and quantitative) for final submission to block grant application based on discussions with FHB staff and other PH staff as needed.	Bina, Lee, MCH Epi	Summary Document	April 30th	Completed
Develop 10 State Priorities 1. Develop list of several priorities based on findings from data gathering phase 2. Meeting with Advisory Group to determine top 10 State Priorities 3. Group Priorities based on levels of MCH Pyramid	Rachel, Eddie Rachel and Eddie Rachel, Eddie, Kathleen	Draft List of Priorities 10 top priorities	April 8st April 11th April 12th	Completed Completed Completed
Develop Performance Measures 1. Set state performance measures (SPM) that can be properly monitored and measured. 2. Set outcome measures (OM) **3.** Develop annual plan and activities for meeting SPMs and OMs	Leadership, Data, PPE, Planners Programs and Services Section	List of State Priorities List of OMs Annual Plan	April 30th April 30th Ongoing	Completed Completed Ongoing
Develop Final Report				

• Write the final report with input from FHB staff, MCH Epi, etc • Submit final report along with final draft of MCH Block Grant Application • Submit web based BG application	Contractor (Deb Bauer)	Final Report Block Grant Application	May 31st May 31st July 15th	Completed Completed Completed

Protocol for Scheduling and Conducting Focus Groups

The Family Health Branch, Policy, Planning, and Evaluation Section will be conducting 6 regional focus groups with communities, their leaders, and community advocacy groups focusing on maternal and child health. Focus groups may include families, parents, family advocates, Family Connection reps, or others. Focus groups will last about 90 -120 minutes each, and consist of about 10-12 people. Tentatively, these focus groups will take place in Atlanta, Macon, Augusta, Savannah/Waycross area, Columbus, and northwest Georgia

Scheduling Focus Groups: Intern will act as primary scheduler for these focus groups.

1. Intern will work closely with the sponsors of the focus group who consist of representatives of Georgia's four Healthy Start Initiatives, the Latin American Association, plus district staff and coordinators in scheduling and implementing these focus groups.
2. Intern will participate in a conference call with the Healthy Start Initiatives that has been scheduled for Monday Jan 10.
3. Intern will work with the sponsors of the focus groups to schedule a location for the focus groups, disseminate publicity materials, and obtain contact information for potential attendees.
4. Intern will develop and maintain a master schedule for all focus groups that will include time and location of group, number of attendees, and a list of confirmed attendees.

Conducting Focus Groups

1. Intern will ensure that all materials needed to conduct the focus group are at location prior to beginning of discuss. Items may include: pens, paper, poster 'Post-its', tape recorder, and name tags.
2. Needs Assessment Lead and Co-Lead (Eddie Towson and Rachel Krause) will be facilitating the discussion groups. Discussion will be based on a survey containing 2 or 3 open-ended questions and 5 to 8 closed-ended questions. During these discussions, the intern will assist in data gathering by taking notes of and/or recording the conversations.
3. Intern may be required to co-facilitate discussion groups as well. Before doing so, intern will familiarize herself with the community in which the group is being conducted, the survey questions, and other information pertinent to conducting a successful discussion.
4. Intern will ensure that all focus group attendees complete a "fee for service" form prior to ending the discussion. These forms will be maintained by the intern and returned to State Office for reimbursement of attendees.

Attachment A: Continued

Upon Completion of Focus Groups:

1. Upon completion of each interview, the intern will type/transcribe all recorded discussion content. This information will be recorded into an existing template that will be provided to the intern.
2. Coding of information obtained in the discussions may need to be done by intern.
3. Intern will pull out key themes about the interview and write a report on interview findings based on provided template.

Focus Groups for MCH Needs Assessment

#	Location	Type	Participants	Date	Facilitator(s)
1.	Atlanta	Urban	Teens	March 05	Contractor (Completed)
2.	Atlanta	Urban	Spanish Speaking MCH population	March 05	Latin American Association (Completed)
3.	Atlanta	Urban	General MCH population	March 05	Contractor (Completed)
4.	Eastman	Rural	General MCH population	Feb 05	Rachel Krause (Completed)
5.	Augusta	Urban	Parents of CSN	Feb 05	Eddie Towson (Completed)
6.	Albany	Rural	Men	March 05	Darrell Sabbs (Completed)
7.	Savannah	Urban/Rural	Teens	March 05	Contractor (Completed)
8.	Atlanta	Internal	FHB Planners	Dec 04	Bina Philip (Completed)
9.	Atlanta	Internal	ICH and HRIFU Coordinators	Jan 05	Eddie Towson and Kathleen Kinsella (Completed)
10.	Atlanta	Internal	CSN and BCW Coordinators	Feb 23, 2005	Kathleen Kinsella and Rachel Krause (Completed)

Attachment B: Protocol for Scheduling and Conducting Key Informant Interviews

The Family Health Branch, Policy, Planning, and Evaluation Section will be conducting about 30 interviews with key stakeholders in maternal and child health representing various sectors. Key informants may be from academia, private providers, health districts, advocacy groups, state legislature or others. Interviews will last about 30-45 minutes each. Intern will serve as primary scheduler and point of contact for interviews. Intern will be provided with a list of names and contact information.

Scheduling of interviews:
Intern will be provided with a script to follow when scheduling interviews. All interviewees will be initially contacted by Friday January 7th. Follow up and confirmation with these contacts will be completed by Tuesday January 11th. If main contact is unable to participate in an interview, intern will ask for suggested substitute. Intern will maintain a master list of contacts and their response to the interview request as well as a master schedule of interviews. All interviews should be completed no later than February 11th.

Conducting Interviews:

1. All interviews should be conducted face to face unless scheduling conflicts make this impossible.
2. Needs Assessment Lead and Co-Lead (Eddie Towson and Rachel Krause) will be conducting the higher-level interviews. These will encompass Agency/Division Directors. Interviews will consist of a survey containing 2 or 3 open-ended questions and 5 to 8 closed-ended questions. During these interviews, the intern will assist in data gathering by taking notes of or recording the conversations.
3. Intern may be required to conduct interviews herself. Before doing so, intern will familiarize herself with the work of the agency/program/etc of the interviewee, the interview questions, and other information pertinent to conducting a successful interview.

Upon Completion of Interviews:

1. Upon completion of each interview, the intern will type/transcribe and condense all recorded discussion content. This information will be recorded into an existing template that will be provided to the intern.
2. Coding of information obtained in the discussions may need to be done by intern.
3. Intern will pull out key themes about the interview and write a report on interview findings based on provided template.

Interviewers: Eddie Towson, Rachel Krause, Rhonda Page, Sean Johnson, Consuelo Campbell, Susan Bertanoschi, Richelle Wright

Key Informant Interviews

- **Claire Westdahl** - Director of Nurse Midwifery at Grady, Board member of Dept of Gynecology and Obstetrics at Emory University
- **Dawn Morgan** - Child and Adolescent Mental Health Program Chief
- **Monique Davis Smith** - assistant professor of family medicine, Mercer University School of Medicine
- **Patricia Rodney, MD** – Director MPH Program, Morehouse
- **Elise Antrobus** – Director of Programs, March of Dimes Georgia Chapter
- **Ester Sherberger** – Exec Director, Parent to Parent of Georgia
- **Gaye Smith** – Exec Director, Family Connection Partnership
- **Karen Minyard** – Exec Director, Georgia Health Policy Center of Georgia State University
- **Sharon K. Collin** - Program Director, Division of Medicaid Administration
- **Adriane J. Saunders-Smalls** - Senior Program Specialist, Department of Community Health
- **Louis Hamrick** - District Program Director. North Georgia Public Health District
- **Marie Mitchell** - Director of Teen Reproductive Health Services at Grady Hospital
- **Melba Hill-Paschal** – Volunteer / Community Advocate
- **Michele Ozumba** - Executive Director, Georgia Campaign for Adolescent Pregnancy Prevention
- **Pat Cota** - Executive Director, OBGYN Society of Georgia
- **Pat White** - Executive Director, Georgia's Governor's Council on Maternal and Child Health

Family Health Branch
Statewide Five Year Needs Assessment

Fact Sheet

What is the Family Health Branch 5 Year Needs Assessment?

The Family Health Branch at the Georgia Division of Public Health believes that healthy, well-educated children and families are the keys to optimal growth and development essential to maintaining safe and economically sound communities. Therefore, we are committed to promoting the physical, mental, spiritual, and social well-being of Georgia's children and families.

As part of this commitment, we are conducting a statewide needs assessment, including an investigation and analysis or environmental scan of some of the key factors that affect maternal, child, and adolescent health in Georgia. During this process, we will be soliciting input directly from Georgians about their health care needs and concerns, and about family health trends in Georgia and nationwide.

How will we use what we learn from the Needs Assessment?

The Family Health Branch has determined some preliminary uses for the environmental scan, including:

- Fulfillment of the US Health Resources and Services Administration's Title V Block Grant needs assessment requirement
- Tools for program and organizational planning and performance measure setting for the Family Health Branch and other statewide stakeholders.

We hope to make the completed needs assessment as useful a tool throughout Georgia as we are sure it will be for us in the Branch. For this reason, a statewide advisory committee, comprised of internal and external stakeholders (including family and community representatives and others), will assist us in determining future use for our findings.

Whom do I contact for more information?

For more information about the 5 Year Needs Assessment, contact Eddie Towson at (404) 463-0406. You may also visit the Family Health Branch website at http://health.state.ga.us/programs/family/.

DHR

B. J. Walker, Commissioner

Georgia Department of Human Resources • Division of Public Health • Stuart T. Brown, M.D., Director
2 Peachtree Street NW • Suite 15.470 • Atlanta, Georgia 30303-3142
404-657-2700 • FAX: 404-657-2715

January 19, 2005

Dear Family Health Stakeholder:

The Family Health Branch at the Georgia Division of Public Health is conducting a statewide needs assessment to investigate some of the key factors that affect maternal, child, and family health in Georgia. Because of your extensive knowledge and work in one of these areas, your input is requested so that a complete picture of the family health environment in Georgia can be developed. Synthesizing what we learn from advocates, district health officers, families, legislators, providers, researchers, and others, will provide a much needed tool for program planning and priority setting. For more information, please see the fact sheet that follows.

We are offering two ways for you to provide your input on issues and trends in maternal, child, and family health in Georgia. They include either a face-to-face interview or a phone interview. Following is a form to select the option that is best accommodating to your schedule. Please return the form via fax to Richelle Wright at 404-463-8953 or respond via e-mail to rawright@dhr.state.ga.us by January 31, 2005. A follow-up call will be forthcoming to confirm your participation.

Thank you for your support in this exciting and challenging process, and for the hard work you do every day for Georgia's families. If you have any additional questions or concerns, please call Eddie Towson the needs assessment project director at 404-463-0406.

Sincerely,

Richelle Wright
Project Intern
Statewide MCH Needs Assessment

ASSESSING THE MATERNAL AND CHILD HEALTH NEEDS OF GEORGIA

The Georgia Division of Public Health, Family Health Branch is seeking consumer input on maternal and child health issues, and needs. Data will also be collected on how the health services provided are perceived, the degree to which they are utilized, and areas where improvement is needed. This is being done in an effort to determine how we may serve this population better and/or in a more appropriate manner. As part of this effort, we are planning these focus groups throughout the state with 10-12 women/men/parents, between the ages of 18-49.

We will not collect information regarding address or immigration status on any participant. We will ask for age of participants, county of residence and country of origin.

The questions are not structured to identify issues within a particular district/agency, but rather to identify the types of information and resources needed, or already in place, to improve health care services for all Georgia residents. We will provide you with a copy of the findings from the focus groups.

We are asking that facilities such as yours serve as partners on this project. We would like to ask that you assist us in recruiting participants. We have a flyer that can assist with recruitment and a sign-up sheet that we will send you. We will provide participants with $25 cash for their time and $200 for space rental, either for your facility or another location.

Our deadline for completing focus groups is **February 28, 2005**. However, we would like to schedule groups as soon as possible. We are asking your assistance in the following:

1. Recruiting 10-12 consumers (women, men, children) for participation in a focus group, including collecting their name and telephone number so that they can receive a reminder call. This task should be completed ***January7, 2005*.**
2. Securing a location for the group. Again we have funds available to pay rental fees.

We will follow up with you within a week. Should you have any additional questions, please contact Eddie Towson (404) 463-0406, email eltowson@dhr.state.ga.us or Rachel Krause (404) 463-0382, email rhkrause@dhr.state.ga.us.

Thank you for your consideration and we hope we will have the opportunity to collaborate with you on this important project.

Georgia Department of Human Resources
Division of Public Health
Family Health Branch

Family Health Branch
2005 MCH Needs Assessment
Consumer Focus Group Questions

1. What are your (your child's/your child with special health needs) most important health needs?

2. Where do you (your child/your child with special health needs) usually get health care services?

3. If local health department, what is your perception of the department?

4. Where do you get health information?

5. What types of medical and other services do you (your child/your child with special health needs) need?

6. What problems/barriers have you (your child/your child with special health needs) encountered in accessing the services that you need?

7. How well are the services you currently receive meeting your (your child/your child with special health needs) needs?

8. Describe/discuss any positive experiences in receiving MCH services?

Family Health Branch
2005 MCH Needs Assessment
Consumer Focus Group Participant Survey

We would like you to answer a few questions about yourself and health services in Georgia. If you do not understand any of the questions, please ask the person conducting this discussion. We are not asking for your name or address and information you share will be confidential. Thank you.

1. How old are you? _____

2. What is your nationality? _____

3. What was the highest grade you completed? _____

4. How long have you lived in the United States? _____

5. What county do you live in? _____

6. Marital Status:

   ❑ Single ❑ Married ❑ Separated ❑ Divorced

   ❑ Widowed

7. How many children do you have? _____

8. Do you use health services in your neighborhood?
   - ❑ Yes
   - ❑ No

9. Overall, how satisfied were you with the health services you received for yourself and/or your child(ren)?
   - ❑ Very satisfied
   - ❑ Somewhat satisfied
   - ❑ Not satisfied at all

10. When you do not feel well, where do you go first for treatment?
    - ❑ Pharmacy
    - ❑ Nurse
    - ❑ Doctor
    - ❑ Clinic
    - ❑ Traditional health practitioner (e.g. cuandero, imam, herbalist, acupuncturist)
    - ❑ Friend/family member
    - ❑ Neighbor
    - ❑ I treat myself
    - ❑ Other _____

11. Have you had a check up in past 12 months for any of the following:
    - ❑ OB/GYN

- ❑ Complete physical
- ❑ Dental
- ❑ Vision/hearing
- ❑ Other _____

12. Have you sought care from an emergency room in the past twelve months?
    ❑ Yes ❑ No

13. Which public health programs are you familiar with?
    - ❑ PeachCare for Kids
    - ❑ Medicaid
    - ❑ WIC
    - ❑ Right from the Start Medicaid
    - ❑ Children 1st
    - ❑ Oral Health
    - ❑ Babies Can't Wait
    - ❑ Children's Medical Services
    - ❑ Services for children with disabilities

    OTHER _____

14. Do you have health insurance?
    ❑ Yes ❑ No

15. Do you use Medicaid?
    ❑ Yes ❑ No

16. Do you use PeachCare for Kids?
    ❑ Yes ❑ No

Family Health Branch
2005 Maternal and Child Health Needs Assessment
Web-Based Stakeholder Survey

We Need Your Input!

The Family Health Branch is committed to involving families, communities, and other interested stakeholders in shaping our direction and the work we do.

Title V legislation requires that the State prepare a statewide needs assessment every five (5) years that shall identify the needs for:

- Preventative and primary care services for pregnant women, mothers, and infants;
- Preventative and primary care services for children; and
- Services for CSHCN.

As part of the 2005 needs assessment process, we are asking for your assessment and input regarding the maternal and child health system in Georgia. The Family Health Branch recognizes your expertise in serving women and families of Georgia; therefore, we would like to ask you to please take a few moments to complete this survey. The information gathered will be used to help guide the work of the Family Health Branch over the next five years.

Thank you for your input throughout this critical process and for your interest in the health and well-being of Georgia's families.

Name Phone
Title E-mail
Organization

1. Which Maternal and Child Health target population do you or your agency / organization serve (check all that apply)?

Lists for Type (women, etc.), Race, and Age

2. What type of organization do you work for/are involved with?
   a. State government agency
   b. Local government agency
   c. Non-profit health agency
   d. Advocacy organization
   e. Academic Institution
   f. Private provider
   g. State legislature
   h. Other

3. What are the **top five** most important health care needs or issues of the population you serve? (Indicate in rank order)

_ Adolescent Health
_ Advocacy
_ Care Coordination
_ Child Care
_ Early Periodic Screening Diagnosis and Treatment (EPSDT)
_ Family Planning
_ Family Support (i.e., parent support groups, family training, advocacy, nutrition, social work)
_ Health Education (Individual)
_ Health Education (Community-wide)
_ Home Visiting
_ Immunization
_ Injury Prevention Lead Screening
_ Lack of Health Care Coverage
_ Newborn Screening (Hearing, Metabolic)
_ Mental Health
_ Oral Health
_ Outreach
_ Prenatal Care
_ Public Education Respite Care
_ Research
_ SIDS Counseling
_ STD Counseling and Testing
_ TB Testing
_ Teen Pregnancy Prevention
_ Translation
_ Transportation
_ Well Baby or Child Care
_ Other

4. What kind of services does your organization provide for men, women, and children ***(check all that apply)***?

☐ Adolescent Health
☐ Advocacy
☐ Care Coordination
☐ Child Care
☐ Early Periodic Screening Diagnosis and Treatment (EPSDT)
☐ Enrollment in Health Care Coverage
☐ Family Planning
☐ Family Support (i.e., parent support groups, family training, advocacy, nutrition, social work)
☐ Health Education (Individual)
☐ Health Education (Community-wide)
☐ Home Visiting
☐ Immunization
☐ Injury Prevention Lead Screening
☐ Newborn Screening (Hearing, Metabolic)
☐ Mental Health
☐ Oral Health

- Outreach
- Prenatal Care
- Public Education Respite Care
- Research
- SIDS Counseling
- STD Counseling and Testing
- TB Testing
- Translation
- Transportation
- Well Baby or Child Care
- Other

5. What are the **top five** challenges that you or your organization have encountered in either delivering services to the MCH population or assuring that they receive services?

   _ Affordable Childcare
   _ Coordination of Services
   _ Cultural Issues/Dynamics
   _ Data to show that programs are working
   _ Funding Unstable
   _ Lack of Affordable Childcare
   _ Lack of Community Volunteers
   _ Lack of Staff (Recruitment and Retention issues)
   _ Marketing and Promotion
   _ Medicaid Reimbursement
   _ Political Environment
   _ Public Awareness
   _ Referrals
   _ Transient Clients
   _ Translation
   _ Transportation
   _ Unfunded Mandates
   _ WIC – Changes to Provider Adequate Supplements
   _ Other
   _ Other

6. What are the gaps in services for the MCH population in your community?

   - Adolescent Health
   - Advocacy
   - Care Coordination
   - Child Care
   - Early Periodic Screening Diagnosis and Treatment (EPSDT)
   - Family Planning
   - Family Support (i.e., parent support groups, family training, advocacy, nutrition, social work)
   - Health Education (Individual)
   - Health Education (Community-wide)
   - Home Visiting
   - Immunization
   - Injury Prevention Lead Screening
   - Lack of Health Care Coverage
   - Newborn Screening (Hearing, Metabolic)
   - Mental Health
   - Oral Health
   - Outreach
   - Prenatal Care
   - Public Education Respite Care
   - Research
   - SIDS Counseling
   - STD Counseling and Testing
   - TB Testing
   - Teen Pregnancy Prevention
   - Translation
   - Transportation
   - Well Baby or Child Care
   - Other

7. What is working well in terms of programs and/or services for the MCH population?

8. What emerging trends have you noted that could/will have an impact on MCH population or MCH services during the next five years?

Family Health Branch
2005 MCH Needs Assessment
Key Informant Interview Questions

Name
Title
Organization

1. Which Maternal and Child Health target population do you or your agency/organization serve?
    - Pregnant women
    - Women
    - Infants
    - Children
    - Adolescents
    - Children with special needs
    - Families

2. What type of organization do you work for/are involved with?
    - Public health agency
    - Non-profit health agency
    - Advocacy organization
    - Private providers

3. What kind of services does your organization provide for women and children?

4. What are the most important health care needs of the population you serve?

5. What are the major barriers your organization faces in providing services to the MCH population?

6. What challenges have you or your organization encountered in either delivering services to the MCH population or assuring that they receive services?

7. What are the gaps in services for the MCH population that your agency targets?

8. What is working well in terms of programs and/or services for the MCH population.

9. What emerging trends have you noted that could/will have an impact on MCH population or MCH services during the next five years?

Family Health Branch 2005 MCH Needs Assessment
Program Coordinator Focus Group Questionnaire

District(s) _____

Programs for which you are responsible

_____

_____

Direct Health Services

(e.g. undocumented population, low birthweight rate, HIV rate among women, lack of access for Medicaid clients, etc.)

What are the major health care needs in your District?

List the needs that you have identified in order of priority for your district, with the highest priority first.

What problems/needs/gaps is your district experiencing in delivering direct services?
(e.g. lack of sufficient number of public health staff, technical assistance needs of public health staff, inability to communicate to clients, client perception of public health, etc.)

What emerging trends will have an impact on direct health services over the next three years?
(e.g. increased number of children under 5 years, decreased number of practicing physicians, continued decrease in number of public health workforce, etc.)

How well are direct health services in your district meeting the needs of the population that you serve?

Family Health Branch 2005 MCH Needs Assessment
Program Coordinator Focus Group Questionnaire

Enabling Services

(e.g. transportation to services, translation services, resources to meet the needs of the family including mental health, respite, WIC, health insurance, etc.)

What are the major enabling services needs in your district?

List the needs that you have identified in order of priority for your district, with the highest priority first.

What problems is your district experiencing in referring clients or in clients accessing to enabling services?
(e.g. lack of reliable transportation, lack of translators in rural areas, lack of mental health resources especially for youth, etc.)

What emerging trends will have an impact on the availability or the accessibility of enabling services over the next three years? (e.g. will the demand/need for enabling services exceed the supply, availability in all geographic areas, right mix of enabling services-what is missing, etc.).

How well are enabling services in your district meeting the needs of the population that you serve?

Family Health Branch 2005 MCH Needs Assessment
Program Coordinator Focus Group Questionnaire

Population Based Services

(e.g. universal newborn screening, oral health services, lead screening, immunization, SIDS, etc.)

What are the major population based health needs or conditions in your district?
(e.g. high rate of maternal morbidity/mortality, high rate of children with high blood lead level, etc.)

List the population based health needs that you have identified in order of priority for your district, with the highest priority first.

What problems is your district experiencing in providing population based services?
(e.g. increasing portion of the population is not receiving timely immunizations, technical assistance (TA) needed in moving from direct to population based services, etc.)

What emerging trends will have an impact on providing population based health services over the next three years?
(e.g. increasing homeless population, serving children in foster care, etc.)

How well are population based services in your district meeting the needs of the population that you serve?

Family Health Branch 2005 MCH Needs Assessment
Program Coordinator Focus Group Questionnaire

Infrastructure

(e.g. data systems, needs assessment, training, quality assurance, monitoring, evaluation, planning, coordination of systems of care, etc.)

What are the major infrastructure needs in your district?
(e.g. social marketing skills, workforce training, leadership and management skills, coordination of services among systems, etc.)

List the needs that you have identified in order of priority for your district, with the highest priority first.

What needs or gaps is your district experiencing in developing the infrastructure needed to provide services?
(e.g. implementing medical home concept, implementing CAPTA, etc.)

What emerging trends will have an impact on your service infrastructure over the next three years?

Save the Date

What: 2nd meeting of the Georgia Maternal and Child Health Five Year Needs Assessment Advisory Committee

When: Monday April 11th

Where: TBD

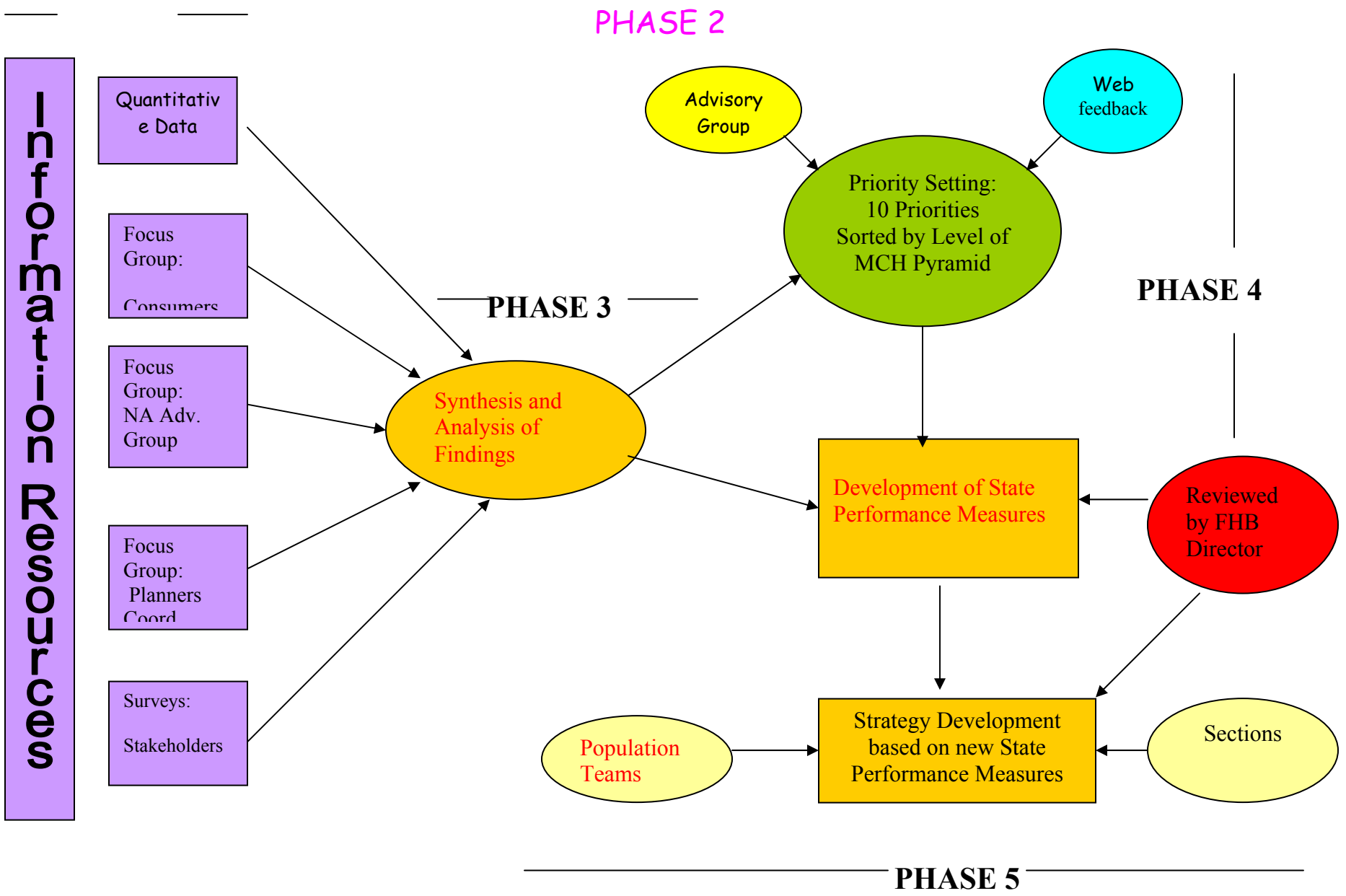
Why: 1. Review needs assessment findings
2. Determination of 10 State MCH Priorities

For additional information please contact:

Eddie Towson
Needs Assessment Coordinator
eltowson@dhr.state.ga.us
404-463-0405

Thanks!

Attachment 2: Family Health Branch 5 Year Needs Assessment Process



Attachment 3 – MCH Block Grant Needs Assessment 2005 Quantitative Data – Sources

INFANTS	**Source**
Infant Mortality (Total, Neonatal and Post Neonatal)	http://oasis.state.ga.us/webquery/infantdeath.html
Causes of Death (All, Black, White)	http://webappa.cdc.gov/sasweb/ncipc/leadcaus.html WISQARS Leading Causes of Death Reports, 1999-2002
Short Gestation (PreTerm/Very Pre Term Births)	http://oasis.state.ga.us/webquery/mch.html
Low Birth Weight	http://oasis.state.ga.us/webquery/mch.html
SIDS Deaths	http://oasis.state.ga.us/webquery/infantdeath.html
Unintentional Injury Deaths	http://oasis.state.ga.us/webquery/death.html
Congenital Anomalies	Analysis of data from Georgia Birth Defects Reporting and Information System (MCH Epidemiology Section, Epidemiology Branch, Division of Public Health)
Newborn Hearing Screening	UNHS Program Data (Office of Infant and Child Health Services, FHB

CHILDREN	**Source**
Causes of Death	http://webappa.cdc.gov/sasweb/ncipc/leadcaus.html WISQARS Leading Causes of Death Reports, 1999-2002
Chronic Disease (1-12 Asthma)	http://oasis.state.ga.uswebquery/death.html
Unintentional Injury Deaths 1-12	http://oasis.state.ga.uswebquery/death.html
Substantiated Abuse and Neglect	http://dfcs.dhr.georgia.gov/DHR-DFCS/DHR-DFCS_CommonFiles/DFCS_KPI_OCTOBER_04.pdf Division of Family and Children Service – Key Performance Indicators, October 2004
Immunizations	http://health.state.ga.us/pdfs/publications/reports/gaimmunizationstudy.03.pdf Georgia Immunization Study 2003 Final Report (MCH Epidemiology Section, Epidemiology Branch)
Oral Health Protective Sealants data	Family Health Branch – MCH Block Grant data from previous years (Limitation: proxy data has been used as denominators for this measure in the absence of an actual denominator)
Lead	Lead Surveillance System (MCH Epidemiology Section, Epidemiology Branch, DPH)

CHILDREN WITH SPECIAL HEALTH NEEDS	Source
Access to Care indicators	http://www.cdc.gov/nchs/slaits.htm (Limitation: this data will be available only when the survey is repeated)

ADOLESCENTS	Source
Pregnancies, Repeat Pregnancies, Births	http://oasis.state.ga.us/webquery/mch.html
Causes of Death (10-19)	http://webappa.cdc.gov/sasweb/ncipc/leadcaus.html WISQARS Leading Causes of Death Reports, 1999-2002
Causes of Injury Deaths	http://webappa.cdc.gov/sasweb/ncipc/leadcaus.html WISQARS Leading Causes of Death Reports, 1999-2002
AIDS and STDs (by race and gender)	http://www.ph.dhr.state.ga.us:8090/ehi/owa/epi_run.call_query?query_type=A (Notifiable Disease Epidemiology Section, Epidemiology Branch)
Health Risk Behaviors	2003 Georgia Student Health Survey Report (Chronic Disease Injury and Environmental Epidemiology (CDIEE) Section, Epidemiology Branch, DPH)

WOMEN	Source
Birth Rates, Maternal Mortality, Fetal Death Rates	http://oasis.state.ga.us/webquery/mch.html Reproductive Health Indicators Report (MCH Epidemiology Section, Epidemiology Branch, DPH)
Prenatal Care	http://oasis.state.ga.us/webquery/mch.html http://health.state.ga.us/pdfs/publications/reports/pnss.report.02.pdf
Prevalence of Anemia	Pregnancy Nutrition Surveillance, Georgia, 2002 (MCH Epidemiology Section, Epidemiology Branch, DPH) (Limitation: this data is representative only of the WIC population. Population-based data is available in PRAMS, but cannot be published because of sample size issues)
Diabetes Rates	http://oasis.state.ga.us/webquery/death.html (Hospital Discharge Data)
Breastfeeding Behavior	http://health.state.ga.us/pdfs/publications/reports/pnss.report.02.pdf (Limitation: this data is representative only of the WIC population. Population-based data is available in PRAMS, but cannot be published because of sample size issues.)
Health Risk/Health Promoting Behaviors	http://health.state.ga.us/pdfs/epi/brssreport.02.pdf

	Georgia Behavior Risk Factor Surveillance System (CDIEE Section, Epidemiology Branch, DPH)
Death Rates	http://oasis.state.ga.us/webquery.death.html
DEMOGRAPHICS	**Source**
Female Population (Age, Race/Ethnicity)	http://oasis.state.ga.us/webquery/population.html
Women and Children (area of residence)	http://oasis.state.ga.us/webquery/population.html
Poverty Data	U.S. Census Bureau, 2003 American Community Survey
Language Data	U.S. Census Bureau, 2003 American Community Survey

Other data sources include: Centers for Disease Control, Child Trend Data, KIDS Count, the Kaiser Foundation, Commonwealth Fund, National HealthCare Quality Report 2004, Bureau of Labor Statistics, University of Georgia Carl Vinson Institute of Government, and Atlanta Journal Constitution articles.

Attachment 4 – Needs Assessment Advisory Group Membership List

External Organizations:
Adoptive and Foster Parents Association of Georgia
Family Connection Partnership of Georgia
Family and community advocates (participants in key informant interviews and eight focus groups held statewide in both urban and rural locations)
Georgia Academy of Family Physicians
Georgia Campaign for Adolescent Pregnancy Prevention
Georgia Chapter of the American Academy of Pediatrics
Georgia Governor's Council on Maternal and Infant Health
Georgia Health Policy Center of Georgia State University
Georgia Healthy Start Initiatives

- Atlanta Healthy Start
- Augusta-Richmond County Community Partnership Healthy Start
- Enterprise Healthy Start
- Heart of Georgia Healthy Start

Georgia OB/GYN Society
Grady Hospital Nurse Midwifery Program
Grady Hospital Teen Services Program
Healthy Mothers/Healthy Babies Coalition of Georgia
Latin American Association
March of Dimes, Georgia Chapter
Mercer University School of Medicine, Family Medicine
Morehouse School of Medicine
Parent to Parent of Georgia
Voices for Georgia's Children

Other State-Level Organizations:
Department of Community Health
Department of Education
Department of Juvenile Justice
Division of Family and Children Services
Division of Mental Health, Developmental Disabilities, and Addictive Diseases

Within the Division of Public Health:
FBH Program Coordinators
MCH Epidemiology Branch
North Georgia Public Health District

Attachment 5 – MCH Family Stories

ADOLESCENT HEALTH AND YOUTH DEVELOPMENT

Comprehensive Health Services (Teen Centers)

Initially, when K first came to our teen center, Teen Time, he was quiet and withdrawn. Once he became more trusting of the center's environment, he began displaying disruptive characteristics. He interrupted presentations, drew inappropriate pictures, got into verbal fights, and was even suspected of stealing teen supplies. The staff came to find that his behavior was consistent with his regular school behavior. Because K ignored staff redirection, and seemed oblivious to rules, our disciplinary committee feared it was inevitable that K would eventually be expelled from the center. Then one day the program was closed due to a school holiday. K, however, walked quite a distance from home in hope that the center would be open. When questioned by a staff member about walking such a long distance, K replied, he didn't mind because he "just needed something to do." Another time K was not selected as one of the top 13 youth to attend a horseback riding field trip as an award for positive behavior. K was extremely upset over not being able to go and as a result, that event proved to be a turning point for him. With continual staff support, K not only displayed many hidden talents through his diligent participation in youth development activities through the center, but he now consistently displays exemplary behavior.

Contact: Carolyn Aidman, PhD, Team Leader (404) 657-8377
E-mail: cbaidman@dhr.state.ga.us
http://health.state.ga.us/programs/adolescent/

CHILDREN WITH SPECIAL NEEDS
Babies Can't Wait

Example of a family helped by this program:

Abbie's story, as told by her family in Douglas, Georgia:

We just want to take a moment to send a special thanks to BCW for all they've done for us. Our second child, Abbie, showed some developmental delays after only the first few months of life. She would not bear any weight on her feet, had fine tremors at times, could not tolerate the texture of many foods and exhibited some extreme outbursts. Abbie's pediatrician referred us to Babies Can't Wait. Physical therapists, speech therapists, occupational therapists and instructional specialists visited often over the next year and a half. Each one worked tirelessly with us to help incorporate skills into Abbie's daily routine that would help her to improve. We are sincerely grateful for each and every one that has visited our home to help Abbie. Everyone went above and beyond the call of duty. They were always working diligently to come up with creative ways to help Abbie overcome obstacles and were so kind to include her big sister, Kate, during visits. The caring, compassion and support that were continually shown to all of us proved that these people do not consider this "just a job".

Everyone's hard work paid off. Abbie was able to be discharged from Babies Can't Wait when she was only 2 ½! She will be three in December 2004 and is doing great. She runs, jumps, tumbles, eats about anything, attends preschool and has the regular temper tantrums that any other normal two year old experiences.

Thank you BCW! You made the difference. We are eternally grateful and will never forget you.

CHILDREN WITH SPECIAL NEEDS
Babies Can't Wait

Example of a family helped by this program:

Callie's story, as told by her mother, Julie L., of Wray, Georgia:

In a moment of crystal clear clarity, my breath was taken away at 5:26 pm on October 8, 2003. My daughter and third child, Callie Terese, had just been born and the doctor exclaimed, "Your baby is deformed. She has birth defects – her feet, hands, wrists are all affected." To say I was shocked would be the understatement of the decade. "What does that mean?" was all I could say.

Callie was subjected to every scan available on her tiny 6 lb, 1 oz, 17" body. Were her vital organs functioning properly? Did her brain show signs of damage? What had caused these defects? All I wanted to do was hold my baby and protect her from all of the pokes, prods, and scans. Fourteen hours later, Callie was taken two hours away by ambulance to a large regional hospital with a neonatal unit for more observation and tests. It would be two more days before we learned her diagnosis – Arthrogryposis.

My breath has been taken away many times over these last 13 months by Callie's sheer will and amazing transformations. Through the Babies Can't Wait program, her team of therapists, the nurse specialist, and service coordinator, Callie has built up the strength to stand for periods of time while holding on to a support, pick up small objects, turn pages in books and she has learned to roll anywhere she wants to go. The first time she was able to get her head up over her arm and roll over was truly a breath-taking moment for us all!

Callie will be facing the first of her hip surgeries in early 2005. I am scared for her but I have confidence in our team of caring professionals and know that the Babies Can't Wait team will be there for us. Along the way we've been helped in ways immeasurable by people who started out as Callie's caretakers but have since become friends. Babies Can't Wait is an invaluable program for children and families like mine. I cannot imagine our lives without this amazing provision. Thank you from the bottom of my heart. May Babies Can't Wait and programs like it continue on so that parents like me can look forward to more breath taking moments in the lives of our special children!

CHILDREN WITH SPECIAL NEEDS
Babies Can't Wait

Example of a family helped by this program:

Taylor's story as told by her mother, Ivy, of Albany:

No parent ever wants their child to have problems or developmental delays. Taylor's mother, Ivy, recalls "The doctors told us that the stroke that Taylor experienced before she was born would probably affect her vision, that the right side of her body would be weaker than the left, and that she would likely experience developmental delays." Taylor's family learned about Babies Can't Wait from family and friends and referred Taylor to Babies Can't Wait in Albany when she was three months old.

While in Babies Can't Wait, Taylor received supports and services to enhance her development in the areas of r gross motor, fine motor, and communication. Taylor's mother reports that home visits and sessions were arranged to fit their family's schedule and were even provided in Taylor's childcare setting for a short time. Taylor's progress was visible, especially in the area of communication. She increased her vocabulary and began to express her wants and needs. She has learned to put words together to make 3 or 4 word sentences. When Taylor turned three, she transitioned from Babies Can't Wait to the Dougherty County School System where she now receives speech therapy services.

"Babies Can't Wait was extremely helpful in lending knowledge of available services within the community for which Taylor was possibly eligible. Nobody expects or wants to accept the fact that their child has a developmental delay. However, the fact is that any child needs love and deserves to receive any available assistance or services to help him or her to reach their maximum potential. The Babies Can't Wait program helped my family and I with the assistance Taylor needed in order for her to reach age appropriate milestones. The therapists were very helpful in giving me ideas to work with Taylor on my own. Thanks for giving me such a wonderful opportunity to share my experience about such a great program! I greatly appreciate all that the Babies Can't Wait program has done for my daughter, Taylor! Please continue to inform the public about the Babies Can't Wait program and how it works."

FAMILY STORIES
WOMEN'S HEALTH
Family Planning

Examples of families/individuals helped by this program:

Debra, a patient in her late 40s, had not had a physical in over 15 years because she could not afford it. She was told to come to the non-traditional site in Sumter County where she received a Pap smear and a free mammogram certificate. As she left the clinic, she commented "If it were not for caring people like you, I would've just gone on without getting a Pap smear and mammogram every year". Due to the overwhelming number of recent layoffs in Americus, many other women are now left without medical benefits and have started utilizing services at this site.

A mother in Dooly County brought her 25-year-old mentally handicapped daughter into the clinic for annual exams and Depo Provera injections. The family is low income, but recently had received some extra money. To show their appreciation for the excellent care, kindness and patience that had been shown to her and her daughter, the mother donated part of it to the clinic.

A 17-year old male in Bartow County came in to talk to a nurse about pregnancy prevention and his responsibility in preventing pregnancy and STD. An RN met with the young man and discussed at length the conception process and various methods of birth control and the risk of sexually transmitted diseases. The next day the young man brought his older sister in to meet the nurse and to receive the same information. Both of these clients were extremely grateful for the accurate and complete information the nurse had provided. Subsequently the young man and his girlfriend came in for family planning services, as did the older sister. They stated that they did not know that these services were available before talking the Family Planning staff. They also did not know that the services were confidential and so thorough and affordable. All three planned to share the information with their peers.

While making a home visit to a client concerning birth control methods, a family planning nurse spoke with the client's mom regarding the importance of her receiving routine Pap smears and breast exams. The mom called the clinic for an appointment. Her Pap smear and follow-up revealed she had cervical cancer. The diagnosis resulted in the woman undergoing a hysterectomy, but the cancer was discovered in time to save her life.

A family planning nurse making a home visit to a post partum mom, discovered one of the twins was having difficulty breathing, and checked him for a fever. The child felt very hot. The nurse bathed the child with cold water and took him and his mother to their pediatrician. The doctor reported that the child would have gone into convulsions and died if his symptoms had continued to go unnoticed.

Contact: Christy Sims (404) 657-3151
E-mail: Clsims@dhr.state.ga.us
http://health.state.ga.us/programs/familyplanning

Georgia Department of Human Resources
Division of Public Health
Family Health Branch

Family Story 2002
Women's Health Program
District 2 - Gainesville

Rosa T. has been a Women's Health client since 1994. At that time she had given birth to 9 children with no miscarriages, and one newborn death. She soon became pregnant again, her husband using her pregnancies to keep her in an abusive relationship. By 1999 she was pregnant for the 3rd time since she had been coming to the health department for family planning services. She was year after year trying to have her tubes tied, but having vaginal deliveries and a husband who chose to keep her pregnant, her immigration status did not qualify her for a Medicaid post-partum tubal ligation. At 43 years old, Rosa finally decided enough was enough. We applied through Women's Health Benefits to seek a tubal ligation for her. We arranged for her transportation to Atlanta with a volunteer interpreter, and finally succeeded in providing Rosa with a way to stop the vicious cycle she felt trapped within. Rosa has continued to express her gratitude to the program for all the assistance she received.

NEWS from DHR

Jim Martin, Commissioner

Department of Human Resources • Office of Communications • Jed Nitzberg, Director
2 Peachtree Street, NW • Suite 29-426 • Atlanta, Georgia 30303-3142
Phone: 404-656-4937 • Fax: 404-651-6815

FOR IMMEDIATE RELEASE

JUNE 9, 2003

For information, contact:
Barbara Joye; 404/656-4937
brjoye@dhr.state.ga.us
or
Demetrius Parker; 404/657-6313
dmparker1@dhr.state.ga.us

OPEN LETTER

FATHERS, CAN WE TALK?

by Demetrius M. Parker

To Whom It May Concern:

Fathers, let's challenge ourselves this Father's Day while our wives, families and friends give us the extra attention we crave, to know more and do more about cancer health by just talking with them about cancer screening and early detection. As fathers, we are not generally known for our great ability to talk about the most sensitive subjects, especially when the conversations deal with cancer, mammograms and Pap tests. Many of us may not know what these tests are or what they involve.

In my 16 years of marriage, I've known about my wife's visits to the doctor for her regular mammograms, but I never asked her about them or encouraged her to continue them. Not until I began working with the Department of Human Resources (DHR), Division of Public Health and our partner, the Georgia Cancer Coalition (GCC) did I even ask my wife if she got regular Pap tests. Now that I know better, I am communicating better. We speak more openly about our cancer checkups. I also asked my mom and sisters if they got mammograms and asked my dad and brother if they talked with their doctor about prostate cancer screening.

One out of every two men and one of every three women are at risk of having cancer in their lifetime. Every year in Georgia, more than 14,000 lives are lost to some form of cancer, and this year alone, more than 31,000 new cases will be diagnosed. When breast, cervical and colon cancers are found at early stages, the five-year survival rate is better than 90 percent.

We know from personal experience that when we encourage our wives, families and close friends to take better care of themselves, they are more likely to listen and act. Now, with research from the GCC, DHR, Division of Public Health cancer awareness and education campaign, we can confirm that people are generally more willing to listen to their loved ones on such serious matters. If talking about the 'c' word is still a topic you would rather avoid, get creative with sharing the early detection message. Mail them a cancer information brochure. Discuss a recent news report on cancer, and ask, "Oh, by the way, have you been checked?" Email them the address of a cancer-related website.

No father wants to see his wife, family member or friend experience the pain of cancer. So, this Father's Day please take time to talk about screening for cancer. Learn more about cancer check-ups by calling toll-free, 1.800.4CANCER, or by visiting www.georgiacancer.org. Or call your health care provider or local health department. Because we want to spend as many Father's Day celebrations as we can with our loved ones, let's talk more about cancer prevention. Happy Father's Day. Save a Life. Get Checked.

Editor's Note:

Demetrius Parker is public affairs and media relations manager with the Cancer Control Section, Georgia Department of Human Resources, Division of Public Health. He is available for interviews and can arrange interviews with other leaders of Georgia's cancer awareness and education campaign. Contact him at 404.657.6313.

Family Stories
Women's Health
Men's Health Initiative

I have both high praise and deep gratitude for the Men's Health Initiative. I attended an Initiative sponsored health fair in Atlanta in 2002. In short, the health fair saved my life.

At the age of 72 years, I was unaware that I had a heart condition until a public health nurse examined me at the health fair. She asked if I would consider joining the clinical cardiovascular studies program being conducted by a local medical school. I am very grateful that I joined this program. An MRI revealed that I was suffering from arrhythmia. After further tests, it was discovered that my arrhythmia was probably being caused by medication that I was taking for another health condition. My medications have been adjusted, and my heart is functioning normally.

I would also like to mention the Initiative's publication, A Health Guide for Georgia Men. This informative guide is a daily companion to my inspirational readings.

Family Story
Adolescent Health and Youth Development
Resource Friends and Fathers Program

Kevin Rainey says that after he dropped out of high school, he used to "walk the neighborhood" playing cards and drinking with friends. He was walking taller recently after signing up for a GED course at Central Georgia Technical College and being hired at a local restaurant. Rainey, 21, had been job-hunting unsuccessfully for months until he got in touch with Michael Randall, who runs the Resource Friends and Fathers Program of the Bibb County Health Department.

In the four years since its inception, the program has helped over 4,000 young men obtain health care, substance abuse treatment, employment training, education assistance, and skills in parenting and anger management. The award-winning program is designed for at-risk males or young fathers aged 10 to 24, as well as young men such as Rainey who have few male role models, but no one is turned away.

Rainey learned about the program after it helped his father to find work and transportation several years ago. Rainey's father died last year, and since then, Rainey's relationship with Randall has grown. Randall helped Rainey get his first job several years ago, and Rainey sometimes eats dinner with Randall's family. Randall is proud of his role in the lives of the young men he helps, 70 percent of whom do not have a father at home.

Other Georgia counties have used Bibb's program, the first of its kind in the state, as a model. The program is based on the Resource Mothers Program. The program was born with the primary goal of helping both members of teen couples learn to be responsible parents. After spending time in the program, many young men began paying child support and developing better relationships with their children.

Resource Fathers also teaches young men to control their anger. Anger at two sets of parents who may blame them for a pregnancy; anger at the fathers who may have abandoned them, and anger at the girlfriends who may make demands upon them.
Because many teen mothers are abused, young men need to understand the emotional effects of abuse on women and their children.

Rainey is rising above his mistakes. He has obtained gainful employment and hopes to pursue an associate's degree in electronics. Randall, who knew Rainey often scavenged and repaired broken radios and televisions from around his Bloomfield neighborhood suggested the idea.

"He helped me want to learn more, to get on with my own life, and be better, " Rainey.

Adolescent Health

Bibb County Health Department
Resource Friends and Fathers Program

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Adolescent Health and Youth Development

The following story demonstrates a successful AHYD Teen Center Youth Advisory Board Member.

Shaneria is a remarkable young woman. She is an integral part of my life and why my interest in Adolescent Health is so incredibly strong. When I met Shaneria in the fall of 2000 she was this incredibly shy young lady who would not look you in the eye or answer a question unless it required a head nod. Shaneria was selected for the Clarke County Health Department Youth Advisory Board because she expressed, in her interview, her desire to be involved in a positive activity so she could be a positive role model for her sisters. She is definitely a positive role model for her family as well as myself.

Shaneria lives in a housing authority in the city of Athens. She has four sisters, a brother and two wonderful parents. I met Shaneria's family almost immediately after Shaneria joined the Youth Advisory Board. They are very proactive parents and were afraid that Shaneria might be headed down the wrong path. Shaneria had been getting in trouble at school and was failing all of her classes. Her parents had a very hard time helping Shaneria with her school work because neither of her parents can read or write at an advanced level. One afternoon she and I were working on a Youth Advisory Board activity when she admitted that she could not read. She explained how frustrating it was to sit in class and not understand what was going on and how teachers did not believe her when she told them she could not read. Due to the teacher's lack of understanding and Shaneria's frustration she became extremely hostile towards everyone and increasingly involved in risky behaviors/situations. Due to her lack of educational achievement and negative behaviors Shaneria was removed from the college preparatory track and placed on an educational track that would not allow her to pursue a higher education.

Involvement in The Youth Advisory Board allowed Shaneria to focus her energy on a positive experience and it allowed the time for friendships to grow. Together Shaneria, her parents and I worked to help her with schoolwork by having tutors and teachers give Shaneria the extra attention that she needed. We also worked closely with the school counselor to head off many of the problem behaviors that Shaneria was displaying in and out of the classroom. With the schools help we also reworked Shaneria's schedule for her to be returned to an educational track that would be challenging, but would allow her to excel and pursue a higher education if she desired.

Shaneria has grown so much throughout the Youth Advisory Board experience. She has come alive right in front of my eyes. She has a new confidence and self-assurance. She has told me countless times how the Youth Advisory Board has changed her life for the better and how it has been the best experience. She truly believes in this program and the benefits it has for all the students involved. This program has allowed Shaneria to grow into an incredible young woman who is full of dreams and ambitions and now believes that she will make them come true.

Katie Davis, Youth Advocate and Abigail Gunter, Youth Coordinator for the Northeast Health District created the Clarke County Youth Advisory Board program. The Youth Advisory Board serves as a guide for the Health Department's Adolescent Health staff in the creation of policies, programs, and activities to promote positive youth development. The Board provides insight to issues affecting youth in the Clarke County Community. The Youth Advisory Board consists of 17 members ranging in age, culture, gender and socioeconomic status. All members

attend middle or high school in Clarke County. Each Youth Advisory Board Member provides insight into problems that are affecting their peers and act as their own advocates for change.

WOMEN'S HEALTH
Violence Against Women

Example of a family helped by this program:

"I never thought my 17 year old daughter would be the victim of rape. It was a traumatic experience for our whole family. It was the first time as a mother; I did not know what to do. I knew the impact it could have on my daughter's life, and I was beyond scared. I was in shock and a friend convinced me to call Rape Response. It was the most difficult call I had to make. The lady on the other end of the phone was so kind and responsive. We made an appointment and I had to force my daughter to go. It was so hard to walk through those doors. They confirmed the reason our world was falling apart. At that moment it felt like "the angels" of Rape Response put their arms around us and held us together. The pieces were scattered, but did not keep falling.

It took a long time, but the counselors helped us put the pieces back together, one at a time. Every time I felt weak and ready to fall apart, I would call or go see my counselor and she would give me the strength to carry on. I had to be strong for my daughter. She relied on me everyday. I was her strength, and Rape Response was mine.

For months, we had our good days and bad days. I knew I had help, just a phone call away. Rape Response treated our whole family, meeting us late one afternoon when the stress became too much for my youngest daughters.

Eventually, the pain became duller, my daughter started to heal. Yes, she was a victim, but now she is a survivor! She has moved onto to a successful career, and a successful relationship with a wonderful man. There are not words to express my appreciation. I am very thankful for the Rape Response Program. They helped my family to survive this horrible crime

Contact: Rhonda Simpson (404) 657-3147
E-mail rlsimpson@dhr.state.ga.us
http://health.state.ga.us/programs/vaw

Georgia Department of Human Resources
Division of Public Health
DHR

MORE FAMILY STORIES

(1)
Tommie, a family planning patient at the non-traditional site in Sumter County, "delivered" a special Christmas treat bag to all of the employees in appreciation for the services she received at this clinic. Tommie became unemployed in August 2001 due to the closing of the company that she worked for. She states that "if it were not for the services provided through the Sumter County Health Annex that she would not be able to get her annual exam or her Depo Provera shot". She not only lost her job; she lost her health insurance. The treat bag "is just a way to show my appreciation for the kindness I have been shown at the clinic." Like Tommie, due to the overwhelming number of recent layoffs in Americus, many women are now left without medical benefits. Many new clients have started utilizing services at the Annex because they do not have the finances to seek a physician's care. With family planning services, these women would go without proper health care services, such as pap smears, mammograms and methods of birth control.

(2)
Matia, a Hispanic woman, came in with her daughter to get a physical exam and Pap smear. She had not had a Pap smear in 20 years because she did not feel comfortable seeing the physician. Matia's daughter told her about the clinic (Matia gets her annual exam and birth control at this clinic). Matia talked with her mother and she agreed to come in. Matia and her daughter were very happy about the care she received. They left with a big smile on their face and stopped to thank everyone for the care the mother had received. Matia later told the nurses that she did not know what she would do without the services of the clinic.

(3)
Tracy, a client who was diagnosed with an STD, brought the nurses a card and candy because she was so impressed and thankful for the compassion she was shown when she received the positive test results. She stated that if she had been at the doctor's office, she would have been hurried out the door. At the clinic she was given time to comprehend and ask questions about the STD diagnosis.

(4)
Debra, a patient in her late 40's, had not had a physical because she could not afford it in over 15 years. She was told to come to the non-traditional site in Sumter County. She received a Pap smear and a free mammogram certificate. As she left the clinic she commented "If it were not for caring people like you, I would've just gone on without getting a Pap smear and mammogram every year". She stated that she would be sure to tell all of her friends about the clinic.

(5)
Patty, a 26 year old, is a new patient in Dooly County. She recently started receiving her birth control pills in the family planning clinic. Her baby is a few months old. Her Pap smear that she received during her pregnancy was a LGSIL. She had a Biopsy at the Doctor's office, but had not returned for Cryo. Her husband had died in September from an accident at work. She had no insurance and her only income was her husbands Social Security. She has three children in all.

The clinic was able to provide her with birth control pills and assist her with getting the cryo procedure done. She will be coming into the clinic to get repeat pap smears every three months for her follow up. The clinic staff also tried to give her the compassion and support she needed.

(6)
A mother brings her 25-year-old mentally handicapped daughter into the clinic in Dooly County for annual exams and Depo Provera injections. At the last visit , the mother gave a one hundred dollar donation. The family is

low-income status but recently had received some extra money and they wanted to show their appreciation for the excellent care, kindness and patience that had been shown to her and her daughter.

FAMILY STORIES
ORAL HEALTH

Submitted by Charles H. Roszel, DDS, Dental Director, Northwest Georgia Health District

The Northwest Georgia Health District is a ten county district with a population of 511,142. There are no public health dental facilities in any of the county departments of health. The only facility servicing this population is our mobile dental van. There are a small number of dental providers, approximately 5%, who do see Medicaid/PeachCare patients on a sporadic basis. This translates into a tremendous need for dental care in not only the school age population but in the adult population as well.

It is, therefore, especially important to offer preventive care to elementary school age children. If we are unable to intercept and prevent dental problems in this population it is unlikely that they will be able to access care as adults. The scope of untreated dental problems in our elementary school age children is disturbing. As a consequence of this the problems we see among low-income young adults is astounding. The reality is these people have no option for care at this time. I have included a sample of some of the common problems we see in schools as we travel around our district.

This is a before and after of a fourteen year old in Bartow County.

We were able to treat him over the summer.

These types of problems affect school attendance, self-esteem, school performance and test scores, not to mention the accompanying pain and suffering. These problems are all preventable. The public health dental program is vital in our district.

Contact: Thomas E. Duval DDS, MPH; 404-657-2575 Fax: 404-657-7307

E-mail: teduval2@dhr.state.ga.us

http://health.dhr.state.ga.us/programs/oral

Georgia Department of Human Resources
Division of Public Health
Family Health Branch

New mobile dentistry unit brings care to local schools

By NATALIE DAVIS—Dublin Newspaper, December 2004

Walk through the halls of Saxon Elementary these days and students are all smiles, but not for any of the likely suspected reasons. Odd as it may seem, Saxon students are flashing their pearly whites in anticipation of a dentist's visit and they don't even have to leave campus. A new mobile dentistry unit arrived at Saxon a few weeks ago to provide dental services for students through the Georgia Oral Health Prevention Program. Locally, the unit serves elementary-aged students at 19 schools within the South Central Health District. Organizers say the program aims to provide care to students who otherwise may not have the chance to see a dentist on a regular basis. "We are trying to reach children that don't have access to a dentist," said Debra Smith, DMD, during a recent visit to Saxon. In addition to Laurens, the South Central Health District also serves Johnson, Montgomery, Telfair, Pulaski, Treutlen, Wheeler and Wilcox counties. The mobile unit, new this year, serves students from pre-kindergarten through fifth grade. The unit was made possible primarily through funding from the state oral health program and child health grants. After finishing up at Saxon, the unit will move to Moore Street Elementary before traveling to Dodge County. About 250 students at Susie Dasher Elementary received care earlier this year. While the health district has always provided referrals for dental care and has its own oral health prevention program, this is the first time a local unit has been equipped to see students on school campuses. A few years ago another mobile dentistry for children, the Conyers-based Help A Child Smile, came to town and served several hundred area students. Smith said while there are a number of dental care programs that visit schools, there are only eight mobile-type units in the state like the one South Central has. Smith said the South Central Health District has the largest patient to dentist ratio in the state, and she noted that about 75 percent of practicing dentists are located in northern Georgia. The target for the program is children who do not already see a family dentist regularly. Smith said the health district has always done prevention programs, just never actual treatments at a school site. "Our trailer was just equipped last year," she said. Parents are contacted about the program prior to a visit, and receive a letter regarding the condition of their child's teeth. Parents must complete a form prior to their child's treatment. "We take forms until the day we leave," said dental assistant Kristi Selph. "We try to be flexible." Each student also receives a goody bag with items to promote healthy hygiene and proper care. "Every student gets a toothbrush, toothpaste and dental floss whether they see us or not," said Smith. The unit's three-member staff, two dental assistants and a dental hygienist, is able to do fillings, extractions and basic dental care such a fluoride treatments right on campus. The staff typically sees around 25 children a day. Dublin City Schools Registered Nurse Trini Stevenson said she often sees students come in with cavities, toothaches and ongoing infection. She said the goal is always to try to keep students at school so they do not have to miss any instruction time, but that is not always possible. With the mobile unit however, they can receive proper dental care right on campus. "A lot of the children we serve don't actually get to see a dentist's office," said Stevenson. "This is just a wonderful experience for the kids." Stevenson said a number of parents of the students they serve simply do not have access to dental care because they lack insurance coverage. She noted that children whose parents work for the state cannot get PeachCare coverage, and many single parents are not able to afford dental insurance. Many do not receive Medicare either. “That leaves so many of our children in the gap," said Stevenson, adding the program helps to meet their needs. “It just touches so many kids that would never have the opportunity to see dentist, she said. "Every child deserves great dental care. It's just a rewarding program."

Attachment 6: Levels of the Pyramid Matrices

Maternal & Child Health Block Grant

Direct Services ▪ Enabling Matrix

Population Group:			***Women's Health***					
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
1. Family Planning • Medical Services • Counseling & Education	Collaboration with Chronic Disease, STD, HIV, Office of Pharmacy to provide services.	Lack of knowledge and resources to reach target population in each district.	Work currently being done by districts	Lack of funds for outreach	Yes	y	yes	y
	Regional Training Center for Family Planning	Growing diverse population, requiring longer visits and interpreters services	Language Line Pool of interpreters	Time for staff training and funds for interpreters and translation services		y		y

Population Group:					***Women's Health***			
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	***Indicate Yes or No***			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
					Direct	**Enabling**	**Direct**	**Enabling**
	Public health nurses, nurse practitioners, expanded role nurses, other FP staff providing services	*Inadequate funding and rising cost of contraceptives and screening technologies	Patient assistance programs. PH pricing and collaboration with OOP to find lowest prices	Districts not always aware of how to access info on lowest prices for contraceptives		y		y
	Federal & State Funding	Clinics not operating efficiently (long wait times for appts and at clinic visit) and not using best practices.	Consultation with Health Metrics or other companies providing TA on best practices.	Funds to pay for consultation More and more mandates (federal and state) added to services that consume resources, both time and staff.		y		y
	Client fees Medicaid fees	*Shrinking Medicaid dollars – inadequate reimbursement	DPH work with CMOs			y		y

Population Group:				***Women's Health***				
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
2. Regional Perinatal Services	Specialty Physicians	Geographic Location	Outreach education for hospital & Providers	Lack of statewide participation	Yes	y	yes	y
	Specialty Nurses	Lack of participation by hospitals	Transportation – Maternal & Neonate	Limited air transport	yes	y	yes	y
	Social Workers	Lack of required standards that are enforceable statewide				y		y
	Developmental specialists	Lack of identify for risk appropriate care	Developmental follow-up clinics	Lack of statewide participation		y		y
	Transport staff regional perinatal coordinators	Trained staff not being utilized in some areas within the state				y		y

Maternal & Child Health Block Grant

ICH Direct Services □ Enabling Matrix

Population Group: Infant and Child Health								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
1. Newborn screening for metabolic disorders and hemoglobinopathies	Hospitals/ tertiary centers	Early hospital discharges	System of services/ providers	Full time data/ programming person	Yes	No	Yes	Yes
	Private providers	Public awareness	Educational CD and web site	None		Yes		Yes
	PH Clinics	Inadequate blood samples	State law	Needs to be strengthened/ expanded to add tests and charge fees		Yes		Yes
	State Lab	Strength of legislation	Policy/ procedure manual	None		Yes		Yes
	Tracking system		Advisory Committee	None		No		Yes

Population Group: Infant and Child Health								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
2. Newborn Hearing Screening and Intervention	Hospitals	Cost of disposables, insurance coverage, equipment updates	Children 1st referral forms, incentive program, loaner equipment	Referral protocols, intervention services	Yes	Yes	Yes	Yes
	Private providers	Education and awareness mechanisms for reporting education	Georgia Chapter of American Academy of Pediatrics	Tracking linkages		Yes		Yes
	Public Health Clinics	Not enough staff, tracking system	EBC	Statewide database/registry, delays in EBC info		Yes		Yes
3. Periodic Health Exams • Screening • Evaluation • Referral	PH clinics Private providers	Public awareness, cost	Outreach, Medicaid	Not enough staff, Private vs. Public Health	Yes	Some No	Yes	Yes Yes

Population Group: Infant and Child Health								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
4. Screening for at risk children	Children 1st	Insufficient number o PH staff	EBC Screening/referral forms	Timely data, lack of data systems (tracking)	Yes	Same	Yes	Yes Yes
• Identification		Transportation	Public awareness activities	Multiple languages				
• Assessment		Public awareness		Staff funding (assessment)				
• Referral				Lack of community resources to meet needs				
• Tracking								

Provide a brief narrative that indicates 1) existing issues, 2) concerns, and 3) emerging issues.

1. Inadequate community based services and/or providers in some areas for children identified with a disorder through newborn screening, well child screening, etc.
2. Meeting the needs of an increasingly multi-cultural population; public awareness and outreach activities in different languages; difference in health behaviors in different groups, availability of interpreters, etc.
3. Inadequate and/or fragmented databases needed to identify and fill gaps and link existing databases.
4. Lack of, or inadequate, third party coverage for health services.

5. Provision of health check screens shifted from public health clinics to GBHC providers, which does not allow for follow-up.
6. The increased use of methamphetamine results in child abuse and neglect, and more children entering foster care.

Maternal & Child Health Block Grant

Direct Services ▪ Enabling Matrix

Population Group: Adolescent Health and Youth Development								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
Comprehensive Adolescent Health Services	AHYD Teen Centers FHB Comprehensive Health Centers Family Involvement Youth Development Coordinators MI Clinic, Savannah	Managed care restructuring Politics Community opposition Transportation Hours of operation Stabilizing funding Staff turnover DHR reorganization	Annual medical campaign Community Involvement TA/training Teen/Adult Advisory Boards Implementation of District work plans DHR Assets Modules Medicaid/ PeachCare DHR Faith Initiative and tool kit State Office Regional Training Program School Health Nurse CYCC	No./location of centers Stabilize funding Male medical health staff Male heath educators Teen sensitive and culturally diverse health educators and materials Language barriers Youth enrolled in Medicaid and PeachCare Funding Community Involvement Programs/ organizations Funding Male Involvement	Yes	Yes	Yes	Yes

Population Group: Adolescent Health and Youth Development								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
Postponing Sexual Involvement	Grady contract AHYD Teen Centers FHB Family Planning	Funding Recruitment Funding statewide Abstinence-only media campaign Regional marketing workshops	CYCC AHYD Youth Development services G-CAPP	Male Health Educators, more Community Involvement promotion and social marketing	Yes	Yes	Yes	Yes
Family Involvement	HB Services AHYD Teen Centers – Parent Advisory Councils DHR Policy for Teen/Centers	Communication Planning Participation	Families 1st, Family Connection, DHR Faith Initiative and tool kit DHR/FHB services AHYD Family Involvement Asset Module	Male Health Educators, more Community Involvement Promotion and social marketing	Yes	Yes	Yes	Yes

Population Group: Adolescent Health and Youth Development								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
Public Education and Awareness	AHYD services FHB services PH Liaison District community specialists STD/HIV Abstinence Campaign funding	Multilingual staff Ongoing funding - sustainability Media communication support No longer funding Male Involvement and Community Involvement programs	Family Connection Faith organizations District Medicaid Right from Start personnel	Multilingual parents and service providers Multilingual materials Multilingual FHB/AHYD websites Funding – sustainability, infrastructure	Yes	Yes	Yes	Yes

Population-Based Services ▪ Enabling Matrix

Population Group: Adolescent Health and Youth Development								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Population-Based Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Population Based**	**Enabling**	**Population Based**	**Enabling**
Abstaining adolescents	HR 457 implementation – AHYD Community Outreach Programs Youth Development Coordinators Parent Advisory Councils	Politics, community opposition, media, peer pressure, language and cultural barriers, DHR restructuring	CYCC, G-GAPP, local school boards, Family Connection, parental and community involvement, social marketing campaigns, AHYD subcontractors, school after school programs	*See previous page	Yes	Yes	Yes	Yes

Population Group: Adolescent Health and Youth Development								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Population-Based Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Population Based**	**Enabling**	**Population Based**	**Enabling**
Sexually active adolescents (contraceptive and non-contraceptive)	AHYD Outreach Programs DHR Policy on Teens/Centers	Politics, community opposition, peer pressure, media, objective counseling/ training, funding for Male Involvement and Community Involvement programs, funding for social marketing campaigns, funding for community recreation, socialization programs (e.g., after school/ summer)		Parental consent, lack of male educators and male health staff	Yes	Yes	Yes	Yes

Population Group: Adolescent Health and Youth Development								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Population-Based Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Population Based**	**Enabling**	**Population Based**	**Enabling**
Pregnant and parenting adolescents	Resource Mothers/ Fathers (Outreach/Case Management), Comprehensive Adolescent Health Services, Community Outreach Programs, Alternative schools, Case Management Programs, PEP Program	PeachCare and Medicaid enrollment, Politics, education/job training, resources Child care Coordinating local partnerships with AHYD HIPPA Data systems	Women's Health Services, Infant & Child Health Services, WIC, DOE/DOL, Education, training, parent training	Medicaid and PeachCare enrollment, lack of male educators, economic, education incentives, funding, social marketing	Yes	Yes	Yes	Yes

Population Group: Adolescent Health and Youth Development								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Population-Based Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Population Based**	**Enabling**	**Population Based**	**Enabling**
Intentional and Unintentional Injury Prone Adolescents	Comprehensive Adolescent Health Centers, DHR Office of Injury Prevention, DHR MHDDAD, DHR Violence Against Women, PEP Program	Women's Health (sexual assault prevention), funding	Infant & Child Health, DOL, DJJ, GOMS, Suicide Prevention Services, Violence Prevention Services, Unintentional Injury	Social marketing, coordination across state agencies, local partnerships with AHYD programs, lack of resources, social marketing, community/ parental involvement	Yes	Yes	Yes	Yes

Maternal & Child Health Block Grant

Direct Services ▪ Enabling Matrix

Population Group: Adolescent Health and Youth Development								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
Substance abusing adolescents	Comprehensive Adolescent Health Services, MHDDAD, FHB CSN, Women's Health, alternative schools	Parental/ community involvement, media, peer pressure, environmental setting, MHDDAD	Comprehensive Adolescent Health Services, MHDDAD, FHB CSN, Women's Health, alternative schools	Social marketing, local partnerships with AHYD programs	Yes	Yes	Yes	Yes

Population Group: Adolescent Health and Youth Development								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
Obese adolescents	Comprehensive Adolescent Health Services, Nutrition Grant	Parental/ community involvement, media, peer pressure, environmental setting, MHDDAD	Comprehensive Adolescent Health Services, MHDDAD, FHB CSN, Women's Health, alternative schools	Social marketing, local partnerships with AHYD programs	Yes	Yes	Yes	Yes

Maternal & Child Health Block Grant

Direct Services ▪ Enabling Matrix

Population Group: CSN								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
Medical Surgical Services • Pharmacy services • Cardiology • Pulmonary • Neurological • Orthopedic • Metabolic • Chromosomial • Vision • Hearing	Specialty clinics (11 districts), CMS staff, pvt specialists and subspecialists , University, Health Science Centers	Funds, provider reimbursement, family transportation and drug costs, child care, limited number of neurologists, respite care, translators/ interpreters	DMA transport, interpreters	Need legislative changes, unreliable and/or insufficient transportation, inadequate numbers and training	Yes	Some respite care	Yes	Yes

Population Group: CSN								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
Case Management Services	BCW staff, CMS staff, private and public providers	Cultural/ language, inadequate number, inadequate case management training	Interpreters, CMS Care Coordinators in place for 3 years	Inadequate numbers and variety	Yes	No except for case mgt		Yes
Developmental Services • Physical therapy • Occupational therapy • Speech language • Transportation • Nutrition • Nursing • Audiology • Psychological • Respite • Vision • Social Work • Family training • Special instruction	BCW staff and coordinators, parent educators, parent to parent organizations	Family transportation, respite care, child care, cultural/ language, loss of family income (to provide care or take child to appointments)	Interpreters	Inadequate numbers and variety	Yes	Some respite and child care	Yes	Yes, no assistance with loss of family income

Population Group: CSN								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
Genetic treatment	9 District Clinics, 9 Genetic Nurses, 2 Medical Genetics	Family travel – long distances, GA Medicaid reimbursement for out-of-state tests, limited number of interpreters and medical specialists, lack of services available statewide	Interpreters	Inadequate numbers and variety	Yes		Yes	

Maternal & Child Health Block Grant

Population-Based Services ▪ Enabling Matrix

Population Group: CSN								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Population-Based Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Population Based**	**Enabling**	**Population Based**	**Enabling**
Developmental health and medical services • Screening • Evaluation • Monitoring • Transition	Public and private providers, District coordinators and staff	Family transportation, cultural/ language, insufficient number of providers, respite and child care, loss of family income to go to services	DMA transportation, interpreters, public awareness activities	Inadequate / unreliable transportation, insufficient # and variety	Yes	No/some	Yes	Yes

Population Group: CSN								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Population-Based Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Population Based**	**Enabling**	**Population Based**	**Enabling**
Referral services	Children 1st, other PH programs, health providers and hospitals, community day care, local school system	Family transportation, cultural/ language, insufficient number of providers, respite and child care, loss of family income to go to services	Cultural/ language interpreters	Insufficient # and variety	Yes	Yes	Yes	Yes
High Risk Infant Follow-Up, Home Visiting, Case Management Referrals	County and district staff	Funding for positions in PH, transportation to referral services	Cultural/ language interpreters	Insufficient # and variety	Yes	Yes	Yes	Yes

Maternal & Child Health Block Grant

Direct Services ▪ Enabling Matrix

Population Group: Children with Special Needs (Babies Can't Wait)								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
1. Developmental Services: • Screening • Evaluation • Assessment • Assistive Technology • Audiology • Family Training, Counseling • Health • Medical Diagnostic • Nursing • Nutrition • Occupational Therapy • Physical Therapy • Psychology • Special Instruction	Public & Private providers	Language, cultural barriers Insufficient numbers of providers in some areas of the state and some specialties	DHR interpreters	Lack of Medicaid funding for Evaluation and Assessment activities	X	X	X	X
	District Coordinators & Staff		BCW Training & Technical Assistance providers	Funding for direct services from third party insurers is limited	X	X	X	X
	Public Awareness, Social Marketing campaign		BCW partnerships with GAYC, DOE, DECAL for training of child care and early childhood educators	Need additional training to reach broader throughout the state	X	X	X	X

Population Group: Children with Special Needs (Babies Can't Wait)								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
• Speech Therapy • Social Work • Transportation • Vision Services	Collaboration & liaisons with state OT, PT, SLP associations				X	X	X	X
2. Parent Support & Education • Parent Educators • Parent to Parent of Georgia Central Directory, Database of Resources, support groups, and parent matching • Project SCEIs training • Parent Conferences • Parent representation on SICC & LICCs	17 parent educators	Would benefit from additional parent educators			X	X	X	X
	Parent to Parent of Georgia	Accessible by phone and web – barrier if families don't have phone and/or computer access			X	X	X	X
	SCEIs training modules; parents as co-trainers and attendees	None			X	X	X	X

Population Group: Children with Special Needs (Babies Can't Wait)								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
	District parent conferences	Transportation and child care are often barriers to participation			X	X	X	X
	Linkages with DOE Parent Mentors				No	Yes	No	Yes
3. Early Intervention Case Management Services	Adequate numbers of BCW staff & contracted service coordinators	Need more bilingual service coordinators			X		X	
	Monthly service coordinator orientation	None	Medicaid funding for service coordination	Medicaid funding issue – BCW service coordinators don't get paid if another case manager from another program bills first in the month.	X		X	

Population Group: Children with Special Needs (Babies Can't Wait)								
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	***Indicate Yes or No***			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
					Direct	**Enabling**	**Direct**	**Enabling**
	Project SCEIs training requirements & continuing education requirements for service coordinators	None			X		X	
	Web-based training options				X		X	

Maternal & Child Health Block Grant

Direct Services ▪ Enabling Matrix

Population Group (HRIFU)	Children With Special Needs/ HIGH RISK INFANT FOLLOW-UP (HRIFU)							
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
• Assessment Of family/infant health status, home environ. • Parent education/ support • Anticipatory guidance re: development • Monitoring • Referrals • Assistance w/ identifying & accessing community resources • Colloborate w/ PCP as appropriate	PH Nurses @ County & District level.	Lack of adequate #'s staff IN County/District HD, to deliver the services, thus some counties without staff to deliver services as demand exceeds supply; Inadequate funding for Program; positions go unfilled for months/years Families that do not want home visits;	Case Management **or** PH Nursing Problem focused Services (start 1 July '05) Home Visiting.	Staff training & development. Staff required to provide services to clients in several different programs & often have to provide clinic services that generate income, rather than make home visit. Lack of State Office staff to provide TA to Districts/counties.	Yes	Yes,	Yes	Yes
	District HRIFU Coordinators	Co-Ordinate several programs; can't Provide TA/support to county staff			yes	yes	yes	Yes

Population Group (HRIFU)	Children With Special Needs/ HIGH RISK INFANT FOLLOW-UP (HRIFU)							
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	***Indicate Yes or No***			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
					Direct	**Enabling**	**Direct**	**Enabling**
	Children 1st	Length of time to get EBC down load varies by districts & if referred maybe 3 weeks or more from time of hospital discharge. To 1st visit. Lack of referrals to program.						
	Quarterly Meetings, between District & SO Manager	Moving from face to face Meetings to using VICS						
	RPC & Tertiary Hospitals (as referral sources)	Need mechanism to be able to refer selected babies to HRIFU before or @ time of hospital discharge.						

Maternal & Child Health Block Grant

Population-Based Services ▪ Enabling Matrix

Population Group: HRIFU	**Children with Special Needs: HIGH RISK INFANT FOLLOW UP (HRIFU)**							
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Population-Based Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Population Based**	**Enabling**	**Population Based**	**Enabling**
1. Public Awareness and Child Find Activities for population of infants needing HRIFU services.	GDPH web site							
	Program & Legislative Fact Sheets							
	Districts Report quarterly on Child Find Activities							

Direct Services ▪ Enabling Matrix

Population Group: Oral Health								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
Dental Services • Prevention • Treatment	Public Health Dentists Hygienists Pvt. Providers	Lack of funding statewide Language/ cultural barriers Lack of collaboration/ coordination with service providers of target population (Medicaid/CHC) Lack of services for adults	Screenings/ referral Counseling/ education Dental sealants Education Emergency care services Lack of transportation of dental equipment for onsite school prevention services Data base maintenance and follow up of students served	Limited providers Hours of service Lack of follow-up Appropriate training Lack of uniform screening procedures Limited services for 19 years (+) age group	Yes	Yes	Yes	Yes

Population Group: Oral Health								
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	***Indicate Yes or No***			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
					Direct	**Enabling**	**Direct**	**Enabling**
Fluoridation • Water systems • School based	GRWA, CDC, DNR, dentist, hygienist, WIC, nutritionist	Lack of daily testing (small systems) Lack of training		Professional training for plant operators	Yes	Yes	Yes	Yes

Population Group: Oral Health								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Direct Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Direct**	**Enabling**	**Direct**	**Enabling**
HeadStart screenings and referrals	PH dentists Hygienists 'WIC	Need more providers for referrals, screenings Training for new dental graduates to treat young children	HeadStart collaborations HeadStart Forums Increased access to care through screenings and referrals		Yes	Yes	Yes	'Yes

Maternal & Child Health Block Grant

Population-Based Services ▪ Enabling Matrix

Population Group: Oral Health								
					Indicate Yes or No			
					Is Family Health Branch Currently Playing A Role		**Should Family Health Branch Be Playing A Role**	
Population-Based Services	**Existing Resources**	**Gaps and Barriers**	**Existing Enabling Services**	**Gaps in Enabling Services**	**Population Based**	**Enabling**	**Population Based**	**Enabling**
Spit/chewing tobacco • Counseling • Education • Referral	PH dentist, DH, GA Spit Tobacco Education Program Nutritionists DOE	Adequate funding Coordination with Public School systems	Coordination with other programs	Limited providers Appropriate training for providers Outreach Age/culture appropriate educational material	Yes	Yes	Yes	
Early childhood caries • Counseling/ education Screening/referral	PH dentist, DH, WIC, Nutritionist					Yes	Yes	

Attachment 7

Acronyms

AAP	American Academy of Pediatrics
ACOG	American College of Obstetrics and Gynecology
AHYD	Adolescent Health and Youth Development
ALA	American Lung Association
ALL	Action Learning Lab
AMCHP	Association of Maternal and Child Health Programs
BCW	Babies Can't Wait
BRFSS	Behavior Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CHC	Community Health Center
CHIP	Child Health Insurance Program
CHOA	Children's Healthcare of Atlanta
CMO	Care Management Organization
CMS	Children's Medical Services
CSHCN	Children with Special Health Care Needs
CSN	Children with Special Needs
CYCC	Children and Youth Coordinating Council
DCH	Department of Community Health
DECAL	Department of Early Care and Learning
DFCS	Division of Family and Children Services
DJJ	Department of Juvenile Justice
DHR	Department of Human Resources

DHSCI	Developmental Health Systems Capacity Indicator
DM	Disease Management
DMA	Department of Medical Assistance
DMHDDAD	Division of Mental Health, Developmental Disabilities, and Addictive Diseases
DOE	Department of Education
DOL	Department of Labor
DPH	Division of Public Health
DSPS	Diagnostic Screening and Prevention Services
ECCS	Early Childhood Comprehensive System
EMA	Eligible Metropolitan Area
EPIC	Educating Physicians in Their Community
EPSDT	Early Periodic Screening, Diagnosis and Treatment
FHB	Family Health Branch
FPL	Federal Poverty Level
GAASP	Georgia Addressing Asthma from a State Perspective
GADS	Georgia Access to Dental Services
GAYC	Georgia Association for Young Children
GBDRIS	Georgia Birth Defects Registry Information System
GBHC	Georgia Better Health Care
G-CAPP	Georgia Campaign for Adolescent Pregnancy Prevention
GCC	Georgia Cancer Coalition
GRITS	Georgia Registry of Immunization Transactions and Services
GSAMS	Georgia Statewide Academic and Medical System

HCCG	Healthy Child Care of Georgia
HD	Health Department
HMHB	Healthy Mothers Healthy Babies
HRIFU	High Risk Infant Follow Up
HSCI	Health Systems Capacity Indicator
ICH	Infant and Child Health
IHP	Interfaith Health Program
LBW	Low Birth Weight
LEP	Limited English Proficient
MACDP	Metropolitan Atlanta Congenital Defects Program
MCH	Maternal and Child Health
MH	Mental Health
MHDDAD	Mental Health Developmental Disabilities and Addictive Diseases
M&I Council	Maternal and Infant Council
MOD	March of Dimes
MSA	Metropolitan Statistical Area
NBS	Newborn Screening
NOM	National Outcome Measure
NPM	National Performance Measure
NTD	Neural Tube Defects
OASIS	Online Analytic Statistical Information System
OH	Oral Health
OHP	Oral Health Program

OHS	Oral Health Summit
OID	Other Infant Deaths
ORS	Office of Regulatory Services
PCM	Perinatal Case Management
PH	Public Health
PHN	Public Health Nurse
PPE	Policy, Planning, and Evaluation
PRS	Pregnancy Related Services
RSM	Right from the Start Medicaid
RSV	Respiratory Syncytial Virus
SCHIP	State Child Health Insurance Program
SOM	State Outcome Measure
SPM	State Performance Measure
SSDI	State Systems Development Initiative
SI	Sensory Impaired
SIDS	Sudden Infant Death Syndrome
UNHSI	Universal Newborn Hearing Screening and Intervention
VLBW	Very Low Birth Weight
VFC	Vaccines for Children
WH	Women's Health
WIC	Women, Infants, and Children
YDC	Youth Development Coordinator
YRBS	Youth Risk Behavioral Surveillance Survey